Filing at a Glance

Company:	BEST Life and Health Insurance Company
Product Name:	Group Stand Alone Dental
State:	Tennessee
TOI:	H10G Group Health - Dental
Sub-TOI:	H10G.000 Health - Dental
Filing Type:	Form/Rate
Date Submitted:	04/30/2013
SERFF Tr Num:	BLHI-129004056
SERFF Status:	Closed-Approved
State Tr Num:	H-130558
State Status:	Approved
Co Tr Num:	FORM FILING
Implementation Date Requested:	01/01/2014
Author(s):	Paul Peatross, Margie Mergen
Reviewer(s):	Vicky Stotzer (primary), Brian Hoffmeister, Melissa Merritt, Art Lucker
Disposition Date:	08/12/2013
Disposition Status:	Approved
Implementation Date:	

State Filing Description:
G SHOP DEN P
GPD-PPO-POL-0113TN
group SHOP dental plan - adult and pediatric

State: *Tennessee* **Filing Company:** *BEST Life and Health Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Group Stand Alone Dental*
Project Name/Number: *Form Filing/Exchange Products*

General Information

Project Name: Form Filing
Project Number: Exchange Products
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Trust
Filing Status Changed: 08/12/2013
State Status Changed: 08/12/2013
Created By: Margie Mergen
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: BEST Life is domicilied in Texas. This filing has not been submitted in Texas.
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: Margie Mergen

Filing Description:
BEST Life and Health Insurance Company – NAIC No. 90638
FEIN: 95-6042390

List of Forms:
GAD-PPO-POL-0113TN - Group Adult Dental Policy
GAD-PPO-CERT-0113TN - Group Adult Dental Certificate
GAD-PPO-SOV-0113TN - Group Adult Dental Statement of Variability
GAD-PPO-EAP-0113TN - Group Employer Application
GPD-PPO-POL-0113TN - Group Pediatric Dental Policy
GPD-PPO-CERT-0113TN - Group Pediatric Dental Certificate
GPD-PPO-SOV-0113TN - Group Pediatric Dental Statement of Variability

Dear Sir or Madam,

On behalf of BEST Life and Health Insurance Company, please find enclosed the Forms Filing . This filing is to meet the requirements for offering stand alone dental in the Tennessee Exchange. Our filing includes 2 products for the Small Group Market. These forms do not replace previously filed forms and do not deviate from generally accepted standard insurance practices.

These stand alone dental plans are being offered through the Beneficial Employees Security Trust, which is situsedin Utah. The forms will correspond to the following Exchange markets as follows:

For the SHOP Market:
- Pediatric Only EHB Dental Plan: - GPD-PPO-CERT-0113TN
- Adult (without Pediatric EHB) - GAD-PPO-CERT-0113TN

Should you have any questions or concerns regarding this filing, please contact me directly at the number listed below or via email. I appreciate your time and consideration.

Sincerely,

State: *Tennessee* ***Filing Company:*** *BEST Life and Health Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Group Stand Alone Dental*
Project Name/Number: *Form Filing/Exchange Products*

Margie Mergen
Compliance Analyst
BEST Life and Health Insurance Company
1-800-433-0088, ext. 226
Fax: 949-222-1004
Email: mmergen@bestlife.com

Company and Contact

Filing Contact Information

Paul Peatross, Senior Vice President
2505 McCabe Way
Irvine, CA 92614

ppeatross@bestlife.com
949-222-2118 [Phone]

Filing Company Information

BEST Life and Health Insurance Company
2505 McCabe Way
Irvine, CA 92623
(800) 433-0088 ext. [Phone]

CoCode: 90638
Group Code:
Group Name:
FEIN Number: 95-6042390

State of Domicile: Texas
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	Texas has a $100 filing fee
Per Company:	No

Company	Amount	Date Processed	Transaction #
BEST Life and Health Insurance Company	$100.00	04/30/2013	69862488

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Vicky Stotzer	08/12/2013	08/12/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Company Response	Vicky Stotzer	07/31/2013	07/31/2013
Pending Company Response	Vicky Stotzer	07/30/2013	07/30/2013
Pending Company Response	Art Lucker	07/24/2013	07/24/2013
Pending Company Response	Art Lucker	07/12/2013	07/12/2013
Pending Company Response	Melissa Merritt	05/31/2013	05/31/2013

Response Letters

Responded By	Created On	Date Submitted
Paul Peatross	08/09/2013	08/09/2013
Paul Peatross	07/31/2013	07/31/2013
Margie Mergen	07/26/2013	07/26/2013
Margie Mergen	07/18/2013	07/18/2013
Margie Mergen	06/13/2013	06/13/2013

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Deadline Has Passed	Note To Filer	Brian Hoffmeister	08/01/2013	08/01/2013
Rates	Note To Filer	Brian Hoffmeister	07/31/2013	07/31/2013
Rates	Note To Reviewer	Paul Peatross	07/31/2013	07/31/2013

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Response time	Note To Filer	Vicky Stotzer	07/31/2013	07/31/2013
High plan only	Note To Filer	Vicky Stotzer	07/30/2013	07/30/2013
Response Needed	Note To Filer	Brian Hoffmeister	07/17/2013	07/17/2013

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Disposition

Disposition Date: 08/12/2013
Implementation Date:
Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
BEST Life and Health Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Cover Letter Accident & Health	Approved	Yes
Supporting Document (revised)	Description of Variables	Approved	Yes
Supporting Document	Description of Variables	Replaced	Yes
Supporting Document	Filing Fees	Approved	Yes
Supporting Document	Readability Certification	Approved	Yes
Supporting Document	Third Party Authorization	Approved	Yes
Supporting Document	Group Rates Certification/Memo - Accident & Health	Approved	Yes
Supporting Document	Accident & Health Group Rates non-experience	Approved	Yes
Supporting Document (revised)	Response to Objections to Rates	Approved	Yes
Supporting Document	Response to Objections to Rates	Replaced	Yes
Supporting Document	CMS Guidance on 24 month wait	Approved	Yes
Supporting Document (revised)	Redline	Approved	Yes
Supporting Document	Redline	Replaced	Yes

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Form (revised)	GROUP POLICY	Approved	Yes
Form	GROUP POLICY	Replaced	Yes
Form	GROUP POLICY	Replaced	Yes
Form	GROUP POLICY	Replaced	Yes
Form	GROUP POLICY	Replaced	Yes
Form (revised)	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Replaced	Yes
Form	CERTIFICATE	Replaced	Yes
Form	CERTIFICATE	Replaced	Yes
Form (revised)	VARIABILITY STATEMENT	Approved	Yes
Form	VARIABILITY STATEMENT	Replaced	Yes
Form	VARIABILITY STATEMENT	Replaced	Yes
Form (revised)	GROUP POLICY	Approved	Yes
Form	GROUP POLICY	Replaced	Yes
Form (revised)	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Replaced	Yes
Form (revised)	VARIABILITY STATEMENT	Approved	Yes
Form	VARIABILITY STATEMENT	Replaced	Yes
Form (revised)	EMPLOYER APPLICATION	Approved	Yes
Form	EMPLOYER APPLICATION	Replaced	Yes
Form	CHILD ORTHO BENEFIT RIDER	Approved	Yes
Form	DENTAL ACCIDENT BENEFIT RIDER	Approved	Yes
Rate (revised)	ACTUARIAL MEMO	Approved	Yes

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Rate	ACTUARIAL MEMO	Replaced	Yes
Rate	ACTUARIAL MEMO	Replaced	Yes
Rate (revised)	PEDIATRIC RATE CALCULATIONS	Approved	Yes
Rate	PEDIATRIC RATE CALCULATIONS	Replaced	Yes
Rate	PEDIATRIC RATE CALCULATIONS	Replaced	Yes
Rate (revised)	ADULT RATE CALCULATIONS	Approved	Yes
Rate	ADULT RATE CALCULATIONS	Replaced	Yes
Rate	ADULT RATE CALCULATIONS	Replaced	Yes

INS CONSULTANTS, INC.

Insurance Regulatory Consultants

419 S. 2nd Street
New Market, Suite 206
Philadelphia, PA 19147
Phone: (215) 625-9877
Fax: (215) 627-7104

TO: Vicky Stotzer
Health Analyst
Policy Analysis Section, Insurance Division
Tennessee Department of Commerce and Insurance

FROM: James Kuklinski, ASA, MAAA
INS Consultants, Inc.

DATE: July 30, 2013

SUBJECT: BEST Life and Health Insurance Company
Group Health – Dental
Forms: GFD-PPO-POL-0113TN, GFD-PPO-CERT-0113TN, GFD-END-CO-0113, GFD-END-SA-0113, GFD-PPO-EAP-0113TN
SERFF tracking Number: BLHI-129004056
Tennessee Tracking Number: H-130558

INS Consultants, Inc. (INS) has reviewed BEST Life and Health Insurance Company's (BEST) group dental filing for plans On and Off the Tennessee Exchange. Please note that rates On and Off the exchange are the same.

This filing was submitted on April 30, 2013 requesting approval of a new Group Family Dental Policy, Child Ortho Benefit Rider, Dental Accident Benefit Rider, related Certificate and Application forms and rates, to meet both the Tennessee regulatory requirements and the Federal Affordable Care Act (ACA) requirements for offering pediatric Essential Health Benefits (EHB) using a stand-alone dental plan in the small group market. The filing covers two pediatric-only plans, Essential Pediatric High and Low, and three additional supplemental dental plans to allow for family coverage, High, Mid, and Basic; the pediatric-only plans incorporate the required pediatric dental EHB, and can each be combined with any of the supplemental plans. The six combinations of Pediatric/Supplemental plans for which rates are provided on the exchange are High/None, Low/None, High/High, High/Mid, Low/Mid, and Low/Basic. All plans are marketed On and Off the exchange. Forms and rates are requested to become effective for new business on and after January 1, 2014.

In support of their request, BEST has provided the proposed new forms and rates, an actuarial memorandum, Rate Data Template, Qualified Health Plan Application Certification, Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification form, and Stand-Alone Dental Plans-Description of EHB Allocation form. The actuarial memorandum includes, inter alia, plan descriptions, pricing assumptions and rate derivation methodologies, the anticipated loss ratio (67.75%), and appropriate actuarial certifications.

After a review of the actuarial memorandum and related supporting materials, INS identified, on July 11 and 24, several matters that required additional clarification or correction. Subsequently, on July 18 and 26, BEST provided clarification and corrections that responded to the questions raised by INS, including a correction to the renewability provision so that the coverage was guaranteed/conditionally renewable instead of optionally renewable.

INS has reviewed the submission in its entirety. INS has checked for compliance with Tennessee loss ratio requirements, as well as for compliance with ACA requirements with respect to Actuarial Value. The anticipated loss ratio exceeds the Tennessee standard of 55% for guaranteed renewable business of this kind, and the Actuarial Values, at 85% for High plans and 70% for Low plans, fall within +/-2% of the 85% standard for High plans and 70% standard for Low plans under ACA. INS's analysis also included (but was not limited to) a review of the rate material, trend assumption, retention, administrative expense breakdown, and rate data template. Based on INS's review, the rates are acceptable, the retention and administrative expenses are reasonable, the Actuarial Values appear to be calculated using a methodology that is reasonable, and the rates appear to be consistent across rating parameters and by plan differences.

Based on INS's review, and on the certifying statements of BEST's opining actuary, INS suggests that the subject filing is compliant with Tennessee and ACA regulatory requirements. Based on this conclusion, INS suggests that the submitted rate schedules are actuarially justified.

If you have any questions or would like additional information, please do not hesitate to call or e-mail.

_____

James Kuklinski, ASA, MAAA

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/31/2013
Submitted Date	07/31/2013
Respond By Date	

Dear Paul Peatross,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- GROUP POLICY, GFD-PPO-POL-0113TN (Form)

Comments: In the column headed in network you need to clarify that the deductible does not apply to in network preventive services. The plan deductible options can remain the same. This is not only in the policy but in all the certificates.

Objection 2

Comments: I am not sure what the change you made meets the request.

You need to waive the deductible for preventive services in the high option plan. The original deductibles may remain the same.

This change must be made in the policy and the certificate.

Conclusion:

PLEASE NOTE: The reviewer on this filing is Victoria Stotzer, if you have any questions please call her at at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Vicky Stotzer

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/30/2013
Submitted Date	07/30/2013
Respond By Date	

Dear Paul Peatross,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

Comments: A plan is required to cover EHB is expected to offer benefits substantially equal to those pediatric oral benefits offered by the EHB-benchmark plan

The Benchmark plan for dental has no cost sharing on Class I services. After discussion with the acting Assistant Commissioner, she agrees that a plan that has cost sharing on the Class I services is not substantially equal to the benchmark plan.

Your schedule includes preventive services as being subject to the deductible for in network services.

Conclusion:

PLEASE NOTE: The reviewer on this filing is Victoria Stotzer, if you have any questions please call her at at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Vicky Stotzer

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/24/2013
Submitted Date	07/24/2013
Respond By Date	07/26/2013

Dear Paul Peatross,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- Response to Objections to Rates (Supporting Document)

Comments: Thank you for your response. Original items 1 and 3 have not been addressed, as follows:

1. (Original 1.) A modified actuarial memorandum to reflect the change from using GAD and GPD policy forms to just GFD policy forms; such memorandum should also contain relevant items below; provide modified rates if the rate structure was affected by the above change. Although modified rates have been provided as part of the actuarial material, it appears that the Rate Data Template in the ACA binder for this submission, and possibly the Rating Business Rules Template or other material, have not been updated for changes made since the original filing.

2. (Original 3.) The renewability provision: non-cancellable or guaranteed renewable; the policy language appears to provide optional renewability, which is not allowed by the ACA (PHSA 2703.) Policy form GFD-PPO-POL-0113TN still contains, in PART 7, in the section titled Termination of Group Policy, the language, We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. Such language indicates optional renewability, notwithstanding statements in the filing that the policy is non-cancelable. I think the intent is to be conditionally renewable, which is guaranteed renewable except for the reasons outlined in the ACA, such as non-payment of premium, fraud, market exit, etc. Note also that the term non-cancelable means premiums cannot be increased, whereas the policy allows changes per PART 7.

Conclusion:

.

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Art Lucker

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/12/2013
Submitted Date	07/12/2013
Respond By Date	07/18/2013

Dear Paul Peatross,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- ACTUARIAL MEMO, [GAD-PPO-POL-0113TN, GPD-PPO-POL-0113TN] (Rate)

Comments: Please provide the following:

1.A modified actuarial memorandum to reflect the change from using GAD and GPD policy forms to just GFD policy forms; such memorandum should also contain relevant items below; provide modified rates if the rate structure was affected by the above change.

2. A discussion of compliance with the ACA and State regulations regarding rates and benefits. Please cite the appropriate regulations.

3. The renewability provision: non-cancellable or guaranteed renewable; the policy language appears to provide optional renewability, which is not allowed by the ACA (PHSA 2703.)

4. The California claims experience referred to in the actuarial memorandum.

5. Supporting documentation for the trend rate of 4%.

6. A discussion of the model used (including methodology) to produce the AVs for high and low plans.

7. Explanation of why the Net Costs shown in the rate calculations do not agree with the values obtained by multiplying the Base Costs by the Trend and by the Area factor.

8. The assumptions, and relevant support, used to arrive at the Supplemental tiered rates from the Net Cost and Target Loss Ratio.

9. Supporting documentation for the Base Costs shown in the rate calculations.

10. Related to 2. above, please explain or correct what appears to be a non-compliant provision with respect to the ACA benefit requirements; for pediatric medically necessary orthodontia, the 24 month waiting period appears to amount to the imposition of a pre-existing condition exclusion.

Conclusion:

PLEASE NOTE: The reviewer on this filing is Victoria Stotzer, if you have any questions please call her at at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Art Lucker

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	05/31/2013
Submitted Date	05/31/2013
Respond By Date	

Dear Paul Peatross,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

Comments: This time the jurisdiction is Utah. Tennessee has some authority if you are filing for approval.

Objection 2

Comments: (31) Services not completed on or before the date of termination, you must allow 30 days to complete treatment.

Objection 3

- GROUP POLICY, GAD-PPO-POL-0113TN (Form)

Comments: The eligible dependent than][between 20 and] is an issue currently with our legal area due to the newborn guaranteed issue requirement.

Objection 4

- CERTIFICATE, GPD-PPO-CERT-0113TN (Form)

Comments: (12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;

These are covered benefits under the FEDVIP plan.

Objection 5

- CERTIFICATE, GPD-PPO-CERT-0113TN (Form)

Comments: Are exchange dental plans subject to the same grace period as the health plans?

Conclusion:

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons. If you have any questions, please phone Victoria Stotzer, primary reviewer, at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

Sincerely,

Melissa Merritt

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/09/2013
Submitted Date	08/09/2013

Dear Vicky Stotzer,

Introduction:

Response 1

Comments:

The policy and certificate schedules have been updated.

Related Objection 1

Applies To:

- GROUP POLICY, GFD-PPO-POL-0113TN (Form)

Comments: In the column headed in network you need to clarify that the deductible does not apply to in network preventive services. The plan deductible options can remain the same. This is not only in the policy but in all the certificates.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Redline
Comments:	
Attachment(s):	GFD-PPO-POL-0113TN(3) - redline.pdf
Previous Version	
Satisfied - Item:	*Redline*
Comments:	
Attachment(s):	*GFD-PPO-POL-0113TN(2)-redline.pdf*

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN(3).pdf	Date Submitted: 08/09/2013 By: Paul Peatross
Previous Version								
1	*GROUP POLICY*	*GFD-PPO-POL-0113TN*	*POL*	*Initial*		*43.500*	*GFD-PPO-POL-0113TN(2).pdf*	*Date Submitted: 07/31/2013 By: Paul Peatross*
Previous Version								
1	*GROUP POLICY*	*GFD-PPO-POL-0113TN*	*POL*	*Initial*		*43.500*	*GFD-PPO-POL-0113TN.pdf, GFD-PPO-POL-0113TN_redline.pdf*	*Date Submitted: 07/26/2013 By: Margie Mergen*
Previous Version								
1	*GROUP POLICY*	*GFD-PPO-POL-0113TN*	*POL*	*Initial*		*43.500*	*GFD-PPO-POL-0113TN.pdf, GAD-PPO-POL-0113TN_redline.pdf*	*Date Submitted: 06/13/2013 By: Margie Mergen*
Previous Version								
1	*GROUP POLICY*	*GAD-PPO-POL-0113TN*	*POL*	*Initial*			*GAD-PPO-POL-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

SERFF Tracking #: BLHI-129004056 **State Tracking #:** H-130558 **Company Tracking #:** FORM FILING

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN(3).pdf	Date Submitted: 08/09/2013 By: Paul Peatross
2	CERTIFICATE	GFD-PPO-CERT-0113TN	CER	Initial		43.500	GFD-PPO-CERT-0113TN(3).pdf	Date Submitted: 08/09/2013 By: Paul Peatross
Previous Version								
2	*CERTIFICATE*	*GFD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GFD-PPO-CERT-0113TN.pdf, GFD-PPO-CERT-0113TN_redline.pdf*	*Date Submitted: 07/26/2013 By: Margie Mergen*
Previous Version								
2	*CERTIFICATE*	*GFD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GFD-PPO-CERT-0113TN.pdf, GAD-PPO-CERT-0113TN_redline.pdf*	*Date Submitted: 06/13/2013 By: Margie Mergen*
Previous Version								
2	*CERTIFICATE*	*GAD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GAD-PPO-CERT-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

No Rate/Rule Schedule items changed.

Response 2

Comments:

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

This was addressed in the above comments and attached schedule items.

Related Objection 2

Comments: I am not sure what the change you made meets the request.

You need to waive the deductible for preventive services in the high option plan. The original deductibles may remain the same.

This change must be made in the policy and the certificate.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Redline
Comments:	
Attachment(s):	GFD-PPO-POL-0113TN(3) - redline.pdf
Previous Version	
Satisfied - Item:	*Redline*
Comments:	
Attachment(s):	*GFD-PPO-POL-0113TN(2)-redline.pdf*

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN(3).pdf	Date Submitted: 08/09/2013 By: Paul Peatross
Previous Version								
1	*GROUP POLICY*	*GFD-PPO-POL-0113TN*	*POL*	*Initial*		*43.500*	*GFD-PPO-POL-0113TN(2).pdf*	*Date Submitted: 07/31/2013 By: Paul Peatross*
Previous Version								
1	*GROUP POLICY*	*GFD-PPO-POL-0113TN*	*POL*	*Initial*		*43.500*	*GFD-PPO-POL-0113TN.pdf, GFD-PPO-POL-0113TN_redline.pdf*	*Date Submitted: 07/26/2013 By: Margie Mergen*
Previous Version								
1	*GROUP POLICY*	*GFD-PPO-POL-0113TN*	*POL*	*Initial*		*43.500*	*GFD-PPO-POL-0113TN.pdf, GAD-PPO-POL-0113TN_redline.pdf*	*Date Submitted: 06/13/2013 By: Margie Mergen*
Previous Version								
1	*GROUP POLICY*	*GAD-PPO-POL-0113TN*	*POL*	*Initial*			*GAD-PPO-POL-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

SERFF Tracking #: BLHI-129004056 **State Tracking #:** H-130558 **Company Tracking #:** FORM FILING

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN(3).pdf	Date Submitted: 08/09/2013 By: Paul Peatross
2	CERTIFICATE	GFD-PPO-CERT-0113TN	CER	Initial		43.500	GFD-PPO-CERT-0113TN(3).pdf	Date Submitted: 08/09/2013 By: Paul Peatross
Previous Version								
2	*CERTIFICATE*	*GFD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GFD-PPO-CERT-0113TN.pdf, GFD-PPO-CERT-0113TN_redline.pdf*	*Date Submitted: 07/26/2013 By: Margie Mergen*
Previous Version								
2	*CERTIFICATE*	*GFD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GFD-PPO-CERT-0113TN.pdf, GAD-PPO-CERT-0113TN_redline.pdf*	*Date Submitted: 06/13/2013 By: Margie Mergen*
Previous Version								
2	*CERTIFICATE*	*GAD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GAD-PPO-CERT-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review.

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Sincerely,
Paul Peatross

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/31/2013
Submitted Date	07/31/2013

Dear Vicky Stotzer,

Introduction:

BEST Life appreciates your review of this important filing.

Response 1

Comments:

BEST Life has updated the schedule of benefits on this plan. There have also been modifications to support certificate issuance from our administration system

Related Objection 1

Comments: A plan is required to cover EHB is expected to offer benefits substantially equal to those pediatric oral benefits offered by the EHB-benchmark plan

The Benchmark plan for dental has no cost sharing on Class I services. After discussion with the acting Assistant Commissioner, she agrees that a plan that has cost sharing on the Class I services is not substantially equal to the benchmark plan.

Your schedule includes preventive services as being subject to the deductible for in network services.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Redline
Comments:	
Attachment(s):	GFD-PPO-POL-0113TN(2)-redline.pdf

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN(2).pdf	Date Submitted: 07/31/2013 By: Paul Peatross
Previous Version								
1	*GROUP POLICY*	*GFD-PPO-POL-0113TN*	*POL*	*Initial*		*43.500*	*GFD-PPO-POL-0113TN.pdf, GFD-PPO-POL-0113TN_redline.pdf*	*Date Submitted: 07/26/2013 By: Margie Mergen*
Previous Version								
1	*GROUP POLICY*	*GFD-PPO-POL-0113TN*	*POL*	*Initial*		*43.500*	*GFD-PPO-POL-0113TN.pdf, GAD-PPO-POL-0113TN_redline.pdf*	*Date Submitted: 06/13/2013 By: Margie Mergen*
Previous Version								
1	*GROUP POLICY*	*GAD-PPO-POL-0113TN*	*POL*	*Initial*			*GAD-PPO-POL-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review of this matter.

Sincerely,

Paul Peatross

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/26/2013
Submitted Date	07/26/2013

Dear Vicky Stotzer,

Introduction:

Response 1

Comments:

Please see the attached.

Related Objection 1

Applies To:

- Response to Objections to Rates (Supporting Document)

Comments: Thank you for your response. Original items 1 and 3 have not been addressed, as follows:

1. (Original 1.) A modified actuarial memorandum to reflect the change from using GAD and GPD policy forms to just GFD policy forms; such memorandum should also contain relevant items below; provide modified rates if the rate structure was affected by the above change. Although modified rates have been provided as part of the actuarial material, it appears that the Rate Data Template in the ACA binder for this submission, and possibly the Rating Business Rules Template or other material, have not been updated for changes made since the original filing.

2. (Original 3.) The renewability provision: non-cancellable or guaranteed renewable; the policy language appears to provide optional renewability, which is not allowed by the ACA (PHSA 2703.) Policy form GFD-PPO-POL-0113TN still contains, in PART 7, in the section titled Termination of Group Policy, the language, We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. Such language indicates optional renewability, notwithstanding statements in the filing that the policy is non-cancelable. I think the intent is to be conditionally renewable, which is guaranteed renewable except for the reasons outlined in the ACA, such as non-payment of premium, fraud, market exit, etc. Note also that the term non-cancelable means premiums cannot be increased, whereas the policy allows changes per PART 7.

Changed Items:

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response to Objections to Rates
Comments:	
Attachment(s):	Determination of Age Factors.pdf Summary of Area Factors - TN 06242013.pdf Summary of Normalized Paid to Children 0-19.xlsx Actuarial Memorandum TN - Group July 18 2013.pdf
Previous Version	
Satisfied - Item:	*Response to Objections to Rates*
Comments:	
Attachment(s):	*Determination of Age Factors.pdf* *Summary of Area Factors - TN 06242013.pdf* *Summary of Normalized Paid to Children 0-19.xlsx*

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN.pdf, GFD-PPO-POL-0113TN_redline.pdf	Date Submitted: 07/26/2013 By: Margie Mergen
Previous Version								
1	*GROUP POLICY*	*GFD-PPO-POL-0113TN*	*POL*	*Initial*		*43.500*	*GFD-PPO-POL-0113TN.pdf, GAD-PPO-POL-0113TN_redline.pdf*	*Date Submitted: 06/13/2013 By: Margie Mergen*
Previous Version								
1	*GROUP POLICY*	*GAD-PPO-POL-0113TN*	*POL*	*Initial*			*GAD-PPO-POL-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*
2	CERTIFICATE	GFD-PPO-CERT-0113TN	CER	Initial		43.500	GFD-PPO-CERT-0113TN.pdf, GFD-PPO-CERT-0113TN_redline.pdf	Date Submitted: 07/26/2013 By: Margie Mergen
Previous Version								
2	*CERTIFICATE*	*GFD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GFD-PPO-CERT-0113TN.pdf, GAD-PPO-CERT-0113TN_redline.pdf*	*Date Submitted: 06/13/2013 By: Margie Mergen*

SERFF Tracking #: BLHI-129004056 **State Tracking #:** H-130558 **Company Tracking #:** FORM FILING

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN.pdf, GFD-PPO-POL-0113TN_redline.pdf	Date Submitted: 07/26/2013 By: Margie Mergen
Previous Version								
2	*CERTIFICATE*	*GAD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GAD-PPO-CERT-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*
3	VARIABILITY STATEMENT	GFD-PPO-SOV-0113TN	MTX	Initial			GFD-PPO-SOV-0113TN.pdf	Date Submitted: 07/26/2013 By: Margie Mergen
Previous Version								
3	*VARIABILITY STATEMENT*	*GFD-PPO-SOV-0113TN*	*MTX*	*Initial*			*GFD-PPO-SOV-0113TN.pdf*	*Date Submitted: 06/13/2013 By: Margie Mergen*
Previous Version								
3	*VARIABILITY STATEMENT*	*GAD-PPO-SOV-0113TN*	*MTX*	*Initial*			*GAD-PPO-SOV-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	ACTUARIAL MEMO	GFD-PPO-POL-0113TN	New		Actuarial Memorandum TN - Group July 18 2013.pdf,	07/26/2013 By: Margie Mergen
Previous Version						
1	*ACTUARIAL MEMO*	*GAD-PPO-POL-0113TN, GPD-PPO-POL-0113TN*	*New*		*Actuarial Memorandum TN - Group July 18 2013.pdf,*	*07/18/2013 By: Margie Mergen*
Previous Version						
1	*ACTUARIAL MEMO*	*GAD-PPO-POL-0113TN, GPD-PPO-POL-0113TN*	*New*		*Actuarial Memorandum TN - Group April 30 2013.pdf,*	*04/30/2013 By: Margie Mergen*
2	PEDIATRIC RATE CALCULATIONS	GFD-PPO-POL-0113TN	New		Group Pediatric Rates - TN 06242013.pdf,	07/26/2013 By: Margie Mergen
Previous Version						
2	*PEDIATRIC RATE CALCULATIONS*	*GPD-PPO-POL-0113TN*	*New*		*Group Pediatric Rates - TN 06242013.pdf,*	*07/18/2013 By: Margie Mergen*
Previous Version						
2	*PEDIATRIC RATE CALCULATIONS*	*GPD-PPO-POL-0113TN*	*New*		*Group Pediatric - TN 04302013.pdf,*	*04/30/2013 By: Margie Mergen*
3	ADULT RATE CALCULATIONS	GFD-PPO-POL-0113TN	New		Group Supplemental Rates - TN 06242013.pdf,	07/26/2013 By: Margie Mergen
Previous Version						

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Rate/Rule Schedule Item Changes

3	ADULT RATE CALCULATIONS	GAD-PPO-POL-0113TN	New		Group Supplemental Rates - TN 06242013.pdf,	07/18/2013 By: Margie Mergen
Previous Version						
3	ADULT RATE CALCULATIONS	GAD-PPO-POL-0113TN	New		Group Supplemental - TN 04302013.pdf,	04/30/2013 By: Margie Mergen

Conclusion:

Sincerely,
Margie Mergen

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/18/2013
Submitted Date	07/18/2013

Dear Vicky Stotzer,

Introduction:

Response 1

Comments:

A modified actuarial memo and the revised rates have been provided.

Please see the Actuarial Memo and other exhibits for answers to items #1 through 9. The renewability provision is non-cancellable. We cannot cancel the policy. As long as the group makes payments, they can renew.

The 24 month wait is not a pre-existing condition exclusion. Our policy does not exclude it, it covers it at a later date. We've included from CMS an FAQ. On page 2, they state that a 24 month wait is permissible. They do not see this as violating ACA benefit requirements.

Related Objection 1

Applies To:

- *ACTUARIAL MEMO, [GAD-PPO-POL-0113TN, GPD-PPO-POL-0113TN] (Rate)*

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Comments: Please provide the following:

1.A modified actuarial memorandum to reflect the change from using GAD and GPD policy forms to just GFD policy forms; such memorandum should also contain relevant items below; provide modified rates if the rate structure was affected by the above change.

2. A discussion of compliance with the ACA and State regulations regarding rates and benefits. Please cite the appropriate regulations.

3. The renewability provision: non-cancellable or guaranteed renewable; the policy language appears to provide optional renewability, which is not allowed by the ACA (PHSA 2703.)

4. The California claims experience referred to in the actuarial memorandum.

5. Supporting documentation for the trend rate of 4%.

6. A discussion of the model used (including methodology) to produce the AVs for high and low plans.

7. Explanation of why the Net Costs shown in the rate calculations do not agree with the values obtained by multiplying the Base Costs by the Trend and by the Area factor.

8. The assumptions, and relevant support, used to arrive at the Supplemental tiered rates from the Net Cost and Target Loss Ratio.

9. Supporting documentation for the Base Costs shown in the rate calculations.

10. Related to 2. above, please explain or correct what appears to be a non-compliant provision with respect to the ACA benefit requirements; for pediatric medically necessary orthodontia, the 24 month waiting period appears to amount to the imposition of a pre-existing condition exclusion.

Changed Items:

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response to Objections to Rates
Comments:	
Attachment(s):	Determination of Age Factors.pdf Summary of Area Factors - TN 06242013.pdf Summary of Normalized Paid to Children 0-19.xlsx

Satisfied - Item:	CMS Guidance on 24 month wait
Comments:	See page 2, highlighted text.
Attachment(s):	PM_FAQ10v2_508cr_052313.pdf

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response to Objections to Rates
Comments:	
Attachment(s):	Determination of Age Factors.pdf Summary of Area Factors - TN 06242013.pdf Summary of Normalized Paid to Children 0-19.xlsx

Satisfied - Item:	CMS Guidance on 24 month wait
Comments:	See page 2, highlighted text.
Attachment(s):	PM_FAQ10v2_508cr_052313.pdf

No Form Schedule items changed.

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	ACTUARIAL MEMO	GAD-PPO-POL-0113TN, GPD-PPO-POL-0113TN	New		Actuarial Memorandum TN - Group July 18 2013.pdf,	07/18/2013 By: Margie Mergen
Previous Version						
1	*ACTUARIAL MEMO*	*GAD-PPO-POL-0113TN, GPD-PPO-POL-0113TN*	*New*		*Actuarial Memorandum TN - Group April 30 2013.pdf,*	*04/30/2013 By: Margie Mergen*
2	PEDIATRIC RATE CALCULATIONS	GPD-PPO-POL-0113TN	New		Group Pediatric Rates - TN 06242013.pdf,	07/18/2013 By: Margie Mergen
Previous Version						
2	*PEDIATRIC RATE CALCULATIONS*	*GPD-PPO-POL-0113TN*	*New*		*Group Pediatric - TN 04302013.pdf,*	*04/30/2013 By: Margie Mergen*
3	ADULT RATE CALCULATIONS	GAD-PPO-POL-0113TN	New		Group Supplemental Rates - TN 06242013.pdf,	07/18/2013 By: Margie Mergen
Previous Version						
3	*ADULT RATE CALCULATIONS*	*GAD-PPO-POL-0113TN*	*New*		*Group Supplemental - TN 04302013.pdf,*	*04/30/2013 By: Margie Mergen*

Conclusion:

Sincerely,
Margie Mergen

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/13/2013
Submitted Date	06/13/2013

Dear Vicky Stotzer,

Introduction:

After the fact, we have learned that any policy we offer on the exchange must include the pediatric plan. Because of this, we are revising our policies as follows:

1) We are withdrawing the GPD forms from this filing so that there is only one form that can be used as a child only policy and as a family policy.
2) GAD forms have been converted into GFD forms. F for family. These GFD forms are a combination of the GAD and GPD forms. Makes it simple that you now only have to review one set of forms. We included a redlined version of the GAD policy so that you can see what additions we made to it to convert it into GFD. If this is too confusing, please follow the clean version of GFD.
3) We are removing the Trust from this filing. The employer will now be the policyholder.
4) We are including a cosmetic ortho and supplemental dental accident rider. If these are not allowed, please let us know.

Response 1

Comments:

We are removing the Trust from this filing. Tenneessee is now listed as the jurisdiction.

Related Objection 1

Comments: This time the jurisdiction is Utah. Tennessee has some authority if you are filing for approval.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: BLHI-129004056 **State Tracking #:** H-130558 **Company Tracking #:** FORM FILING

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN.pdf, GAD-PPO-POL-0113TN_redline.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	*GROUP POLICY*	*GAD-PPO-POL-0113TN*	*POL*	*Initial*			*GAD-PPO-POL-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*
2	CERTIFICATE	GFD-PPO-CERT-0113TN	CER	Initial		43.500	GFD-PPO-CERT-0113TN.pdf, GAD-PPO-CERT-0113TN_redline.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
2	*CERTIFICATE*	*GAD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GAD-PPO-CERT-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

No Rate/Rule Schedule items changed.

Response 2

Comments:

May we please get clarity on this? Is there a law you can refer us to? This would help us rewrite this exclusion to comply with TN law.

Related Objection 2

Comments: (31) Services not completed on or before the date of termination, you must allow 30 days to complete treatment.

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Description of Variables
Comments:	
Attachment(s):	GFD-PPO-SOV-0113TN.pdf
Previous Version	
Satisfied - Item:	*Description of Variables*
Comments:	*Plan ranges are included in the Certificates and policies as instructed.*
Attachment(s):	

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN.pdf, GAD-PPO-POL-0113TN_redline.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	*GROUP POLICY*	*GAD-PPO-POL-0113TN*	*POL*	*Initial*			*GAD-PPO-POL-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*
2	CERTIFICATE	GFD-PPO-CERT-0113TN	CER	Initial		43.500	GFD-PPO-CERT-0113TN.pdf, GAD-PPO-CERT-0113TN_redline.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
2	*CERTIFICATE*	*GAD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GAD-PPO-CERT-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*
3	VARIABILITY STATEMENT	GFD-PPO-SOV-0113TN	MTX	Initial			GFD-PPO-SOV-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN.pdf, GAD-PPO-POL-0113TN_redline.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
3	*VARIABILITY STATEMENT*	*GAD-PPO-SOV-0113TN*	*MTX*	*Initial*			*GAD-PPO-SOV-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*
4	GROUP POLICY		POL	Initial				Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
4	*GROUP POLICY*	*GPD-PPO-POL-0113TN*	*POL*	*Initial*			*GPD-PPO-POL-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*
5	CERTIFICATE		CER	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
5	*CERTIFICATE*	*GPD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GPD-PPO-CERT-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

SERFF Tracking #:	BLHI-129004056	**State Tracking #:**	H-130558	**Company Tracking #:**	FORM FILING

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN.pdf, GAD-PPO-POL-0113TN_redline.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
6	VARIABILITY STATEMENT		MTX	Initial				Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
6	*VARIABILITY STATEMENT*	*GPD-PPO-SOV-0113TN*	*MTX*	*Initial*			*GPD-PPO-SOV-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*
7	EMPLOYER APPLICATION	GFD-PPO-EAP-0113TN	AEF	Initial			GFD-PPO-EAP-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
7	*EMPLOYER APPLICATION*	*GAD-PPO-EAP-0113TN*	*AEF*	*Initial*			*GAD-PPO-EAPP-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*
8	CHILD ORTHO BENEFIT RIDER	GFD-END-CO-0113	CERA	Initial		41.100	GFD-END-CO-0113.pdf	Date Submitted: 06/13/2013 By: Margie Mergen

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN.pdf, GAD-PPO-POL-0113TN_redline.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
9	DENTAL ACCIDENT BENEFIT RIDER	GFD-END-SA-0113	CERA	Initial		41.300	GFD-END-SA-0113.pdf	Date Submitted: 06/13/2013 By: Margie Mergen

No Rate/Rule Schedule items changed.

Response 3

Comments:

Please look at the way we revised the age requirements under the Definition of Child. This should help clear up how we will determine eligibility of dependents by age.

Related Objection 3

Applies To:

- GROUP POLICY, GAD-PPO-POL-0113TN (Form)

Comments: The eligible dependent than][between 20 and] is an issue currently with our legal area due to the newborn guaranteed issue requirement.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN.pdf, GAD-PPO-POL-0113TN_redline.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	*GROUP POLICY*	*GAD-PPO-POL-0113TN*	*POL*	*Initial*			*GAD-PPO-POL-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

No Rate/Rule Schedule items changed.

Response 4

Comments:

This exclusion is removed.

Related Objection 4

Applies To:

- CERTIFICATE, GPD-PPO-CERT-0113TN (Form)

Comments: (12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;

These are covered benefits under the FEDVIP plan.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	CERTIFICATE		CER	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	*CERTIFICATE*	*GPD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GPD-PPO-CERT-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

No Rate/Rule Schedule items changed.

Response 5

Comments:

We believe dental plans will be subject to the same grace period as the health plans. We are not sure, outside of the 90 month grace period that would apply to those recieving the subsidy, if there is anything different than the 31 day grace period we included in the policy. Any guidance would be much appreciated.

Related Objection 5

Applies To:

- CERTIFICATE, GPD-PPO-CERT-0113TN (Form)

Comments: Are exchange dental plans subject to the same grace period as the health plans?

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	CERTIFICATE		CER	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	*CERTIFICATE*	*GPD-PPO-CERT-0113TN*	*CER*	*Initial*		*43.500*	*GPD-PPO-CERT-0113TN.pdf*	*Date Submitted: 04/30/2013 By: Margie Mergen*

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Margie Mergen

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Note To Filer

Created By:

Brian Hoffmeister on 08/01/2013 01:11 PM

Last Edited By:

Brian Hoffmeister

Submitted On:

08/01/2013 01:11 PM

Subject:

Deadline Has Passed

Comments:

Our deadline of July 31, 2013 for approval of forms and rates for use on the FFM in Tennessee has passed. As this filing was not approved prior to the deadline, these plans will not be available on the FFM in Tennessee. If you have any questions, please do not hesitate to contact me.

Brian K. Hoffmeister
Director, Policy Analysis Section
Davy Crockett Tower 6th floor
500 James Robertson Pkwy
Nashville, TN 37243
Phone: 615-741-5602
Fax: 615-741-0648

State: *Tennessee* ***Filing Company:*** *BEST Life and Health Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Group Stand Alone Dental*
Project Name/Number: *Form Filing/Exchange Products*

Note To Filer

Created By:

Brian Hoffmeister on 07/31/2013 04:25 PM

Last Edited By:

Brian Hoffmeister

Submitted On:

07/31/2013 04:26 PM

Subject:

Rates

Comments:

Changing the rates is not possible at this time due to the limitations set by HHS for approval.

State: *Tennessee* ***Filing Company:*** *BEST Life and Health Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Group Stand Alone Dental*
Project Name/Number: *Form Filing/Exchange Products*

Note To Reviewer

Created By:

Paul Peatross on 07/31/2013 03:11 PM

Last Edited By:

Paul Peatross

Submitted On:

07/31/2013 03:11 PM

Subject:

Rates

Comments:

Due to the change in the pediatric schedule to remove cost sharing from class 1, the rates need to be updated. BEST Life's actuary is preparing the actuarial memorandum for submission. It should be completed within a half hour.

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Note To Filer

Created By:

Vicky Stotzer on 07/31/2013 09:12 AM

Last Edited By:

Vicky Stotzer

Submitted On:

07/31/2013 09:15 AM

Subject:

Response time

Comments:

You need to respond to the letter by 12:00 today. If the [0][50] indicates the high pland deductible [0] and the low [50], you need to clarify this issue.
Vicky

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Note To Filer

Created By:

Vicky Stotzer on 07/30/2013 10:07 AM

Last Edited By:

Vicky Stotzer

Submitted On:

07/30/2013 10:07 AM

Subject:

High plan only

Comments:

The no cost sharing requirement is regarding the high plan. The low plan can have minor cost sharing to reduce the AV.
Vicky

State:	Tennessee	**Filing Company:**	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Stand Alone Dental		
Project Name/Number:	Form Filing/Exchange Products		

Note To Filer

Created By:

Brian Hoffmeister on 07/17/2013 02:48 PM

Last Edited By:

Brian Hoffmeister

Submitted On:

07/17/2013 02:48 PM

Subject:

Response Needed

Comments:

The approval deadline for this filing is July 31, 2013 since this filing is for plans that will be offered on the FFM in Tennessee. As of today, we have not received a response to our letter citing deficiencies in the filing. In order to meet the July 31st deadline set by HHS, we need to have your response no later than July 24, 2013. This will allow us time to review your response and ask for any additional corrections before the approval deadline.

If you have any questions, please contact Vicky Stotzer at 615-741-6259 or Victoria.stotzer@tn.gov.

Brian K. Hoffmeister
Director, Policy Analysis Section
Davy Crockett Tower 6th floor
500 James Robertson Pkwy
Nashville, TN 37243
Phone: 615-741-5602
Fax: 615-741-0648

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Form Schedule

Lead Form Number: GPD-PPO-POL-0113TN

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 08/12/2013	GROUP POLICY	GFD-PPO-POL-0113TN	POL	Initial		43.500	GFD-PPO-POL-0113TN(3).pdf
2	Approved 08/12/2013	CERTIFICATE	GFD-PPO-CERT-0113TN	CER	Initial		43.500	GFD-PPO-CERT-0113TN(3).pdf
3	Approved 08/12/2013	VARIABILITY STATEMENT	GFD-PPO-SOV-0113TN	MTX	Initial			GFD-PPO-SOV-0113TN.pdf
4	Approved 08/12/2013	GROUP POLICY		POL	Initial			
5	Approved 08/12/2013	CERTIFICATE		CER	Initial		43.500	
6	Approved 08/12/2013	VARIABILITY STATEMENT		MTX	Initial			
7	Approved 08/12/2013	EMPLOYER APPLICATION	GFD-PPO-EAP-0113TN	AEF	Initial			GFD-PPO-EAP-0113TN.pdf
8	Approved 08/12/2013	CHILD ORTHO BENEFIT RIDER	GFD-END-CO-0113	CERA	Initial		41.100	GFD-END-CO-0113.pdf
9	Approved 08/12/2013	DENTAL ACCIDENT BENEFIT RIDER	GFD-END-SA-0113	CERA	Initial		41.300	GFD-END-SA-0113.pdf

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers and any other Eligible Persons under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: ABC Company

Group Policy Effective Date: [XX-XX-XXXX]

Group Policy Number: [XXX]

State of Delivery: Tennessee

Premiums Due On: 1st of each month

First Renewal Date: [XX-XX-XXXX]

[Intentionally Blank Page]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

[

	[BEST Life Child Dental] [Plus] High Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible[– Applies to Class I Services received Out-of-Network as well as Class II and III Services received In-Network or Out-of-Network]	$0	$50
Class I – Basic Services Coinsurance[– Exams, cleanings, sealants, fluoride treatment, x-rays]	100%	90%
Class II - Intermediate Services Coinsurance[– Fillings]	70%	60%
Class III - Major Services Coinsurance[– Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	50%	40%
Class IV Medically Necessary Orthodontic Services Coinsurance	50% [24 Month Wait]	50% [24 Month Wait]

]

[

	[BEST Life Child Dental] Low Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible[– Applies to Class I, II and III Services received In-Network or Out-of-Network]	$50	$100
Class I – Basic Services Coinsurance[– Exams, cleanings, sealants, fluoride treatment, x-rays]	100%	60%
Class II - Intermediate Services Coinsurance[– Fillings]	55%	40%
Class III - Major Services Coinsurance[– Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	35%	20%
Class IV – Medically Necessary Orthodontic Services Coinsurance	50% [24 Month Wait]	50% [24 Month Wait]

]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Basic Services:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;

(13) Palliative treatment of dental pain (minor procedure);

Class II – Intermediate Services:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;
    f. tooth reimplantation;
    g. surgical access of unerupted tooth;
    h. alveoloplasty;
    i. removal of exostosis;
    j. incision and drainage of abscess;
    k. suture of recent small wounds up to five (5) cm
    l. excision of pericoronal gingival;

Class III – Major Services:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);

(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

Class IV – Medically Necessary Orthodontic Services [**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the “Schedule of Benefits” section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;

(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;

(c) partial bony impaction;
(d) complete bony impaction;

(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
(a) root recovery (surgical removal of residual root);
(b) oral antral fistula closure;
(c) removal of a dentigerous or odontogenic cyst;
(d) incision and drainage of an abscess;
(e) removal of lateral exostosis;
(f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
(a) accidental injury requiring oral surgical treatment, or
(b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
(a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
(b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
(a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
(b) implant supported prosthetics;
(c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
(d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;

(e) implant maintenance].

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;
(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;

(3) Inlays or Onlays, 2 or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A dependent child who meets the definition of Eligible Person may be enrolled and covered under this Policy, as follows:

1. A child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that child is nineteen (19) years of age on the renewal date;
2. A child who is older than nineteen (19) years of age on the coverage effective date or renewal date may be covered under the Supplemental Family Dental Insurance, if Supplemental Family Dental Insurance is endorsed onto the policy.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Dependent: An Eligible Person, other than the Eligible Employee, and who is enrolled in and covered under this policy of insurance.

Covered Employee: An Eligible Employee who is enrolled in and covered under this Policy of insurance.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Person:

(1) You [to age 65]
(2) Your lawful spouse or domestic partner [to age 65]; and
(3) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are less than twenty-six (26) years of age; or
(4) A child named in a Qualified Medical Child Support Order will be considered an Eligible Person.

"Eligible Person" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
    (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
    (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or
(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Insured: An Eligible Person who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Pocket Maximum: The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Eligible Employee or Covered Employee.

PART 5 – ENROLLMENT, EFFECTIVE DATE AND TERMINATION DATE

ENROLLMENT

An Eligible Employee must:

(1) Enroll all existing Eligible Persons in accordance with the annual open enrollment period requirements;

(2) Enroll all Eligible Persons within thirty (30) days of one of the following triggering events:
   - (a) The date on which an Eligible Person loses minimum essential coverage;
   - (b) An Eligible Employee adds a new Eligible Person to the family;
   - (c) A person becomes an Eligible Person through marriage, birth, adoption or placement for adoption;

(d) An Eligible Person's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
(e) An enrollee adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
(f) An Eligible Person gains access to new qualified health plans as a result of a permanent move;
(g) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
(h) An Eligible Person demonstrates that they qualify because of other exceptional circumstances.

EFFECTIVE DATE
Your insurance will become in effect as follows:
(1) If enrollment is received between the first (1st) and the fifteenth (15th) day of the enrollment period, coverage will be effective on the first day of the following month; and
(2) If enrollment is received between the sixteenth (16th) and the last day of the enrollment period, coverage will be effective on the first day of the second following month.

TERMINATION DATE
Coverage may be terminated, as follows:
(1) You may terminate coverage with appropriate notice.
(2) We may terminate coverage in the following circumstances:
(a) You are no longer eligible for coverage through the Exchange;
(b) Non-payment of premiums;
(c) Your coverage is rescinded;
(d) We terminate or decertify; or
(e) You change insurance carriers during an annual open enrollment period or special enrollment period.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose

birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the last date paid in full .

Termination of Group Policy: [This Group Policy will terminate if: (1) the Group Policyholder has

performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status.] We may terminate this Group Policy[at any time following the first renewal date]by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known

address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by

Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (A) the due date to pay any required premium (if premium is not paid by that date).
    (B) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (C) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (D) a date which is:
        I. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        II. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact [BEST Life's Customer Service at 1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to [BEST Life and Health Insurance Company, Attn: Appeals, P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 10 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called

"fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

[ENDORSEMENT - SUPPLEMENTAL FAMILY DENTAL INSURANCE

If the Policyholder selected Family Dental Coverage, then this Endorsement modifies, supplements, and becomes a part of the Certificate for Covered Persons over the age of 18 years. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

Dental Plan Schedule of Benefits
For Eligible Persons over 18 years

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible [(Applies to Basic and Major) – 3 Deductible Maximum per Family]	[$0-100]	
Preventive Care Services [Routine oral exam, cleanings, X-rays]	100%	[100-70]%
Basic Services [Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology]	[90-50]%	[80-20]%
Major Services [Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery]	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
[Endodontic Services	[Basic][Major]]	
[Periodontic Services	[Basic][Major]]	

COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS A – Basic Services:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS B – Intermediate Services:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;

(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
  (a) erupted tooth;
  (b) soft tissue impaction;
  (c) partial bony impaction;
  (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
  (a) root recovery (surgical removal of residual root);
  (b) oral antral fistula closure;
  (c) removal of a dentigerous or odontogenic cyst;
  (d) incision and drainage of an abscess;
  (e) removal of lateral exostosis;
  (f) frenulectomy.

CLASS C - Major Services: [Employer groups without continuous, prior coverage for the twelve (12) month period prior to enrolling with Us will have a twelve (12) month Waiting Period before this Policy covers Major dental services.] Major Dental Services are as follows:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  (a) accidental injury requiring oral surgical treatment, or
  (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non- chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  (a) the surgical placement of endosteal implant body including healing cap, where the bone

and soft tissues are sound and healthy;

(b) implant supported prosthetics;

(c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);

(d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;

(e) implant maintenance.]

[ENDORSEMENT – ORTHODONTIC SERVICES

If the Policyholder selected Orthodontic Coverage, then this Endorsement modifies, supplements, and becomes a part of the Certificate for Covered Persons up to the age of 19 years. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

Optional Child Orthodontic Benefit
This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

Schedule of Orthodontic Benefits

Benefit Description	In Network	Out-of-Network
Orthodontic Coinsurance	50%	50%
Calendar Year Maximum	$500	$500
Lifetime Maximum	$1000	$1000

The initial services may be no greater than [1/3][1/2] of the Lifetime Maximum Benefit Amount; thereafter, follow-up visits will be paid equally on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;

Termination of Coverage
Benefits end once braces are removed or when coverage is cancelled, whichever is first.

[Waiting Period
A 12-Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the 12-Month Waiting Period immediately following the effective date of this Plan.]

[Deductible
The Plan's deductible does not apply to this benefit.]]

Exclusion
(1) Medically necessary orthodontic services.
(2) Orthodontic Services for Insureds who are over 18 years of age.

Underwritten by BEST Life and Health Insurance Company]

CERTIFICATE OF GROUP INSURANCE

Issued By

BEST Life and Health Insurance Company

A STOCK COMPANY
(Herein called the "We," "Us," "Company" or "BEST Life")

BEST Life and Health Insurance Company certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Group Policy. The Group Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Group Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

PLAN EFFECTIVE DATE: Insurance is in effect on the date shown on the Certificate Statement of Coverage.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].

[ ] [ ]

President **Secretary**

GROUP PPO DENTAL
NON-PARTICIPATING

THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.

[Intentionally Blank Page]

This Certificate Is Not Valid
Unless There Is a Complete Statement of Coverage

Statement of Coverage

DENTAL

INSURANCE SUBSCRIBER NAME: [JOHN D. DOE]
CERTIFICATE EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):
[JANE DOE 01/01/2014]
[JON DOE 01/01/2014]

PARTICIPATING EMPLOYER NAME: [CUSTOMER NAME]
PARTICIPATING EMPLOYER NUMBER: [TN00XXX0000XX]

[PLAN: [PPO HIGH]
DEDUCTIBLE: [$50]
ANNUAL MAXIMUM: [$1,000]]

GROUP POLICY No.: [XXXXXXXXX]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

[

	[BEST Life Child Dental] [Plus] High Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible[– Applies to Class I Services received Out-of-Network as well as Class II and III Services received In-Network or Out-of-Network]	$0	$50
Class I – Basic Services Coinsurance[– Exams, cleanings, sealants, fluoride treatment, x-rays]	100%	90%
Class II - Intermediate Services Coinsurance[– Fillings]	70%	60%
Class III - Major Services Coinsurance[– Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	50%	40%
Class IV Medically Necessary Orthodontic Services Coinsurance	50% [24 Month Wait]	50% [24 Month Wait]

]

[

	[BEST Life Child Dental] Low Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible[– Applies to Class I, II and III Services received In-Network or Out-of-Network]	$50	$100
Class I – Basic Services Coinsurance[– Exams, cleanings, sealants, fluoride treatment, x-rays]	100%	60%
Class II - Intermediate Services Coinsurance[– Fillings]	55%	40%
Class III - Major Services Coinsurance[– Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	35%	20%
Class IV – Medically Necessary Orthodontic Services Coinsurance	50% [24 Month Wait]	50% [24 Month Wait]

]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Basic Services:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Intermediate Services:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;
    f. tooth reimplantation;
    g. surgical access of unerupted tooth;
    h. alveoloplasty;
    i. removal of exostosis;
    j. incision and drainage of abscess;
    k. suture of recent small wounds up to five (5) cm
    l. excision of pericoronal gingival;

Class III – Major Services:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;

(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

Class IV – Medically Necessary Orthodontic Services [**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the “Schedule of Benefits” section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments;

expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;

(d) complete bony impaction;

(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);

(8) Periodontics (tissues and gums);

(9) Periodontal exam (not in addition to a routine oral exam);

(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;

(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);

(12) Endodontics (pulp capping and root canal); and

(13) Oral surgery:

(a) root recovery (surgical removal of residual root);

(b) oral antral fistula closure;

(c) removal of a dentigerous or odontogenic cyst;

(d) incision and drainage of an abscess;

(e) removal of lateral exostosis;

(f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);

(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;

(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;

(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:

(a) accidental injury requiring oral surgical treatment, or

(b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.

(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:

(a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or

(b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;

(6) Repair or reline of dentures and bridgework[;

(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:

(a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;

(b) implant supported prosthetics;

(c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);

(d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;

(e) implant maintenance].

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;
(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, 2 or more, except with posts or root canal;

(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A dependent child who meets the definition of Eligible Person may be enrolled and covered under this Policy, as follows:

1. A child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that child is nineteen (19) years of age on the renewal date;
2. A child who is older than nineteen (19) years of age on the coverage effective date or renewal date may be covered under the Supplemental Family Dental Insurance, if Supplemental Family Dental Insurance is endorsed onto the policy.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is

satisfied.

Covered Dependent: An Eligible Person, other than the Eligible Employee, and who is enrolled in and covered under this policy of insurance.

Covered Employee: An Eligible Employee who is enrolled in and covered under this Policy of insurance.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Person:

(1) You [to age 65]
(2) Your lawful spouse or domestic partner [to age 65]; and
(3) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are less than twenty-six (26) years of age; or
(4) A child named in a Qualified Medical Child Support Order will be considered an Eligible Person.

"Eligible Person" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
    (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
    (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or
(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Insured: An Eligible Person who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Pocket Maximum: The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Eligible Employee or Covered Employee.

PART 5 – ENROLLMENT, EFFECTIVE DATE AND TERMINATION DATE

ENROLLMENT

An Eligible Employee must:

(1) Enroll all existing Eligible Persons in accordance with the annual open enrollment period requirements;

(2) Enroll all Eligible Persons within thirty (30) days of one of the following triggering events:
   - (a) The date on which an Eligible Person loses minimum essential coverage;
   - (b) An Eligible Employee adds a new Eligible Person to the family;
   - (c) A person becomes an Eligible Person through marriage, birth, adoption or placement for adoption;
   - (d) An Eligible Person's enrollment or non-enrollment in a qualified health plan is

unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

(e) An enrollee adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(f) An Eligible Person gains access to new qualified health plans as a result of a permanent move;

(g) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and

(h) An Eligible Person demonstrates that they qualify because of other exceptional circumstances.

EFFECTIVE DATE

Your insurance will become in effect as follows:

(1) If enrollment is received between the first (1st) and the fifteenth (15th) day of the enrollment period, coverage will be effective on the first day of the following month; and

(2) If enrollment is received between the sixteenth (16th) and the last day of the enrollment period, coverage will be effective on the first day of the second following month.

TERMINATION DATE

Coverage may be terminated, as follows:

(1) You may terminate coverage with appropriate notice.

(2) We may terminate coverage in the following circumstances:

(a) You are no longer eligible for coverage through the Exchange;

(b) Non-payment of premiums;

(c) Your coverage is rescinded;

(d) We terminate or decertify; or

(e) You change insurance carriers during an annual open enrollment period or special enrollment period.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents

have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the last date paid in full .

Termination of Group Policy: [This Group Policy will terminate if: (1) the Group Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of

material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status.] We may terminate this Group Policy[at any time following the first renewal date]by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change

in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact [BEST Life's Customer Service at 1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to [BEST Life and Health Insurance Company, Attn: Appeals, P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

[ENDORSEMENT - SUPPLEMENTAL FAMILY DENTAL INSURANCE

If the Policyholder selected Family Dental Coverage, then this Endorsement modifies, supplements, and becomes a part of the Certificate for Covered Persons over the age of 18 years. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

Dental Plan Schedule of Benefits
For Eligible Persons over 18 years

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible [(Applies to Basic and Major) – 3 Deductible Maximum per Family]	[$0-100]	
Preventive Care Services [Routine oral exam, cleanings, X-rays]	100%	[100-70]%
Basic Services [Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology]	[90-50]%	[80-20]%
Major Services [Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery]	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
[Endodontic Services	[Basic][Major]]	
[Periodontic Services	[Basic][Major]]	

COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS A – Basic Services:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS B – Intermediate Services:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;

(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
  (a) erupted tooth;
  (b) soft tissue impaction;
  (c) partial bony impaction;
  (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
  (a) root recovery (surgical removal of residual root);
  (b) oral antral fistula closure;
  (c) removal of a dentigerous or odontogenic cyst;
  (d) incision and drainage of an abscess;
  (e) removal of lateral exostosis;
  (f) frenulectomy.

CLASS C - Major Services: [Employer groups without continuous, prior coverage for the twelve (12) month period prior to enrolling with Us will have a twelve (12) month Waiting Period before this Policy covers Major dental services.] Major Dental Services are as follows:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  (a) accidental injury requiring oral surgical treatment, or
  (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non- chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  (a) the surgical placement of endosteal implant body including healing cap, where the bone

and soft tissues are sound and healthy;

(b) implant supported prosthetics;

(c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);

(d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;

(e) implant maintenance.]

[ENDORSEMENT – ORTHODONTIC SERVICES

If the Policyholder selected Orthodontic Coverage, then this Endorsement modifies, supplements, and becomes a part of the Certificate for Covered Persons up to the age of 19 years. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

Optional Child Orthodontic Benefit
This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

Schedule of Orthodontic Benefits

Benefit Description	In Network	Out-of-Network
Orthodontic Coinsurance	50%	50%
Calendar Year Maximum	$500	$500
Lifetime Maximum	$1000	$1000

The initial services may be no greater than [1/3][1/2] of the Lifetime Maximum Benefit Amount; thereafter, follow-up visits will be paid equally on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;

Termination of Coverage
Benefits end once braces are removed or when coverage is cancelled, whichever is first.

[Waiting Period
A 12-Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the 12-Month Waiting Period immediately following the effective date of this Plan.]

[Deductible
The Plan's deductible does not apply to this benefit.]]

Exclusion
(1) Medically necessary orthodontic services.
(2) Orthodontic Services for Insureds who are over 18 years of age.

Underwritten by BEST Life and Health Insurance Company]

VARIABILITY STATEMENT

GFD-PPO-POL-0113TN

Title Page – The address of the company may change.

Page 2 – The President and Secretary of the company may change.

Page 3 – Specific to the Client.

Table of Contents – page numbers may change. The subheadings under Benefits and Exclusions will show either the Pediatric Plan provisions only or all provisions

Schedule of Benefits –

- **Policyholder** –Is bracketed to allow this product to be offered to any employer group.
- **Table of Benefits** - We are offering four "supplemental" plan designs and two pediatric dental plans. We have provided the full range of possibilities that would apply. In the final Certificate, only the plans that are selected will appear. A pediatric plan will always be shown.
- **The 80th percentile** – this is bracketed to allow either the 80th or 90th percentile to be offered.
- **Orthodontic benefits** – 24 month wait is bracketed on medically necessary orthodontia to allow no waiting period.
- **Major Dentistry Waiting Period Waiver –** Our supplemental plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate. This section does not apply to pediatric and will only appear below the Supplemental dental plan.

Part 2 Benefits and Exclusions –

- **24 Month Wait for Medically Necessary Orthodontic Benefits –** bracketed to allow for no waiting period.
- **Optional Child Orthodontic Benefits**
- We may offer child orthodontic benefits as an option depending on the size of the group. This whole section is bracketed. Only plans with this option will have this in the certificate.
- We have bracketed the option to pay benefits at 1/3 or ½ of covered benefit. We will market with 1/3, but want the option to change the benefit to ½ for new contracts.
- 12-month wait on orthodontic procedures may apply depending on group size. This statement will not appear on plans that do not have a waiting period. 12 is bracketed to allow 24 month wait.
- **Class III Major Dental Procedures** - We may offer a 12-month wait on Major Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate.
- **Implants** – We may not offer this benefit on all plans.
- **Supplemental Dental Accident Benefit** – this is bracketed in case we do not want to offer this benefit. It is also bracketed in the Schedule of Benefits.
- **Exclusions** – we have bracketed the exclusions for the Supplemental Plan. Implants has been bracketed to match the benefit offering that would or would not be available on the plan.

Effective Date for the Employee - Item #3 is bracketed and will be specific to the Client.

The Client may not want coverage effective on the date the employee qualifies.

Termination of Group Policy – Bracketed for the following:

On exchange:
Termination of Group Policy: This Group Policy will terminate if: (1) the Group Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status. We may terminate this Group Policy by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Off Exchange:
Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

General Provisions
- **Notice of Claim** – Address may change.

Filing a Dental Claim
- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

GFD-PPO-CERT-0113TN **Title Page** –The address of the company may change.

Page 2 – The President and Secretary of the company may change.

Statement of Coverage – Group and Insured information will be provided in the bracketed fields.
- **Subscriber Name –** Specific to individual purchasing the plan.
- **Certificate Effective Date –** Specific to the plan year for the Exchange.
- **Insured name(s) and Effective Dates(s) –** specific to client.
- **Participating Employer and Employer Number** – specific to client.
- **Plan information** – We are transitioning to a new administrative system. Our current administrative system provides plan selection information in the Statement of Coverage. The new administrative system will provide this information in the Schedule of Benefits. The Plan, Deductible, Annual Maximum, waiting period waiver is bracketed because these fields will no

longer be provided once the new system is up and running.
- **Group Policy Number** – Specific to the client.

Table of Contents – page numbers may change. The subheadings under Benefits and Exclusions will show either the Pediatric Plan provisions only or all provisions

Schedule of Benefits –

- **Policyholder** – **Policyholder** –Is bracketed to allow this product to be offered to any employer group.
  - **Table of Benefits** - We are offering four "supplemental" plan designs and two pediatric dental plans. We have provided the full range of possibilities that would apply. In the final Certificate, only the plans that are selected will appear. A pediatric plan will always be shown.
  - **The 80th percentile** – this is bracketed to allow either the 80th or 90th percentile to be offered.
  - **Orthodontic benefits** – 24 month wait is bracketed on medically necessary orthodontia to allow no waiting period.
  - **Major Dentistry Waiting Period Waiver –** Our supplemental plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate. This section does not apply to pediatric and will only appear below the Supplemental dental plan.

Part 2 Benefits and Exclusions –

- **24 Month Wait for Medically Necessary Orthodontic Benefits –** bracketed to allow for no waiting period.
- **Optional Child Orthodontic Benefits**
  - We may offer child orthodontic benefits as an option depending on the size of the group. This whole section is bracketed. Only plans with this option will have this in the certificate.
  - We have bracketed the option to pay benefits at 1/3 or ½ of covered benefit. We will market with 1/3, but want the option to change the benefit to ½ for new contracts.
  - 12-month wait on orthodontic procedures may apply depending on group size. This statement will not appear on plans that do not have a waiting period. 12 is bracketed to allow 24 month wait
- **Class III Major Dental Procedures** - We may offer a 12-month wait on Major Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate.
- **Implants** – We may not offer this benefit on all plans.
- **Supplemental Dental Accident Benefit** – this is bracketed in case we do not want to offer this benefit. It is also bracketed in the Schedule of Benefits.
- **Exclusions** – we have bracketed the exclusions for the Supplemental Plan. Implants has been bracketed to match the benefit offering that would or would not be available on the plan.

Effective Date for the Employee - Item #3 is bracketed and will be specific to the Client. The Client may not want coverage effective on the date the employee qualifies.

Termination of Group Policy – Bracketed for the following:

On exchange:
Termination of Group Policy: This Group Policy will terminate if: (1) the Group

Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status. We may terminate this Group Policy by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Off Exchange:

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

GFD-PPO-EAP-0113TN

Title of Application – plan name is bracketed.

Dental Plan Selection – the plan names are bracketed since the name may change. We are providing the full range of benefits possible within the brackets for each benefit level.

Waiting Period Waiver – We currently offer waiting period waivers for groups based on group size and if they have prior coverage. We would like to offer the same waiting period waivers if we provide waiting periods on major and orthodontic services on our Supplemental plans. This section will be taken out if no waiting periods are offered on the Supplemental dental plans.

GFD-EN-CO-0113

- Address may change.
- 12-month wait on orthodontic procedures may apply depending on group size. This statement will not appear on plans that do not have a waiting period.
- We have bracketed the option to pay benefits at 1/3 or ½ of covered benefit. We will market with 1/3, but want the option to change the benefit to ½ for new contracts. 12 is bracketed to allow for a 24 month wait.
- The Lifetime Maximum and other benefits will appear on the Schedule of Benefits. We have bracketed this in case we want this to appear elsewhere, i.e. the Statement of Coverage.
- Signatures - Officers may change.

GFD-END-SA-0113

- The address may change
- This benefit may be offered at $1,000 or $500. Only one benefit amount will appear, depending on the plan selected.
- Signatures – officers may change.

BEST Life™
BEST Life and Health Insurance Company

[BEST] Dental Plans Employer Application

2505 McCabe Way, Irvine, CA 92614
Requested Effective Date: ☐ 1st or ☐ 15th of the month _____, 20____

Type of Coverage Requested	Supplemental Dental Plans			Essential Pediatric Plans	
Select dental plan	☐ [Advantage]	☐ [Plus]	☐ [Basic]	☐ [High]	☐ [Low]
Calendar Year Deductible	$[0-100]	$[0-100]	$[0-100]	In $0 Out $50	In $50 Out $100
Maximum Benefit Level	$[500-3,500]	$[500-3,500]	$[500-3,500]		
Out-of-Pocket Maximum				$700	$700
Preventive Care Services	In [100-70]% Out [100-70]%	In [100-70]% Out [100-70]%	In [100-70]% Out [100-70]%	In 100% Out 90%	In 100% Out 60%
Basic Services	In [90-50]% Out [80-20]%	In [90-50]% Out [80-20]%	In [90-50]% Out [80-20]%	In 70% Out 60%	In 55% Out 40%
Major Services	In [60-0]% Out [50-0]%	In [60-0]% Out [50-0]%	In [60-0]% Out [50-0]%	In 50% Out 40%	In 35% Out 20%
Endodontics	[Basic][Major]	[Basic][Major]	[Basic][Major]	Major	Major
Periodontics	[Basic][Major]	[Basic][Major]	[Basic][Major]	Major	Major
Child Orthodontics*				☐ Add Cosmetic	☐ Add Cosmetic
Reimbursement Level	[80th][90th] Percentile	[80th][90th] Percentile	[80th][90th] Percentile	80th Percentile	80th Percentile
Employer Choice Option**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Voluntary Option	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

**Certain requirements apply. **Employer is contributing less than 50% for each employee. Please see Plan Brochure for details.*

EMPLOYER/EMPLOYEE INFORMATION

On Payroll	Full-Time	Eligible	Enrolling	Description of Classes not Eligible

Are any employees applying for coverage currently receiving extended benefits under COBRA? ☐ Yes ☐ No *(If yes, please list names below.)*

The Firm's Waiting Period waived for Present Employees? ☐ Yes ☐ No

All new employees are eligible the first of the month following continuous full-time employment of: ☐ 1st of the month following date of hire
☐ 1 Full Calendar Month (standard) ☐ 2 Full Calendar Months ☐ 3 Full Calendar Months

Employer Contribution _____ % for employees _____ % for dependents *(Note: on employer-sponsored plans, Employer must pay at least 50% for employees.)*

Does Employer have proof of comparable group dental insurance for the past twelve (12) consecutive months? ☐ Yes ☐ No *(A copy of your most recent dental bill listing the covered employees and their effective dates must accompany this application.)*

[Supplemental Dental Only: The 12-month wait on Major and Ortho services is waived for employees and groups based on group size and proof of prior coverage for 12 consecutive months on a comparable group dental plan as follows: Employer-sponsored plans: employees with proof of prior coverage only, who are in a group with prior coverage and 5-9 employees enrolled; all employees in a group with 10+ employees enrolled.
Voluntary plans: employees with proof of prior coverage only, who are in a group with prior coverage and 5-9 employees enrolled; all employees in a group with prior coverage, with 10-24 employees enrolled and 50% participation; if 50% participation is not met, waiver will only apply to employees with proof of prior coverage.]

EMPLOYER ACKNOWLEDGEMENT & AGREEMENT

Employer Name				Employer Federal Tax Number	
				( ) -	( ) -
Street Address	City	State	Zip	Telephone Number	Fax Number
Billing Address / P.O. Box	City	State	Zip	Email	
Nature of Firm's Business	SIC Code	Firm's Contact for Service and Administration of the Selected Plans			

I certify that this is a bona fide business with a legitimate business purpose and which has a true employer-employee relationship with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date and denial of all claims incurred.

I understand and agree that the insurance hereby applied for is not effective until this application and the full initial premium is delivered to, received by and approved by BEST Life and Health Insurance Company.

Termination of Coverage—Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the plan; (2) the date the plan is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium; (4) the date the group policy is terminated; (5) the date the group no longer meets minimum participation requirements. The benefits are subject to all the conditions and limitations of the plan.

Eligible dependent coverage terminates on the earliest of the following: (1) when the dependent no longer meets the definition of a dependent; (2) on the first day of the month in which premiums were not paid; or (3) when the member terminates coverage.

FIRM ELIGIBILITY:

A firm or employer must be an active business operation to request coverage. The business must continue on an active basis to retain eligibility for coverage. Coverage will be terminated on the effective date the business ceases active operation. I understand that if my firm drops in size to 1 employee, and if additional employees are not enrolled and active for coverage within 2 months, all of my selected insurance coverage will be cancelled.

FRAUD NOTICE – The following general Fraud Notice is intended to comply with the laws of your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who, knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information may be guilty of committing a fraudulent insurance act which is a crime and may be subject to criminal prosecution.

X / /

Signature of Company Officer | Print Name & Title | Dated

NAVIGATOR REPORT

(Please Print)

Name _____

It is not necessary to complete the following information if you are currently receiving service fees from BEST Life unless changes in address, etc. need to be made. Please sign and date the form below.

Your Agency Name

Address

City | State | Zip

Who Should Receive the Service Fees? ☐ Navigator ☐ Company/Firm

Social Security Number | Federal Tax ID

Date of Birth | License No. | State

Phone No. | FAX No.

Email Address

(Please Complete)
Special Instructions to BEST Life

1. May we contact the client if we need additional information?
   ☐ Yes ☐ No
2. Is this your first case with BEST Life? ☐ Yes ☐ No
3. This is: ☐ an existing client ☐ a new client with my company
4. Send 'New Client Kit' (certificate book, claim forms, etc.) to:
   ☐ The Navigator ☐ The Client
5. The underwriter assigned to my case should contact me?
   ☐ Yes ☐ No

General Agent (GA):

Please list any special handling needed for this client:

I hereby certify that I hold a valid Life, Accident and Health license issued by the state in which this document was executed and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

1. This firm is a bona fide business establishment and participation requirements are being met.

2. I have advised my client not to terminate any existing coverage until this coverage is approved.

3. Coverage, eligibility provisions, waiting periods and limitations have been fully explained to, and understood by, the Employer identified in this document.

4. I have no right to bind, modify or alter provisions of this program.

I understand and agree that the insurance applied for herein does not begin until this application is received and approved by BEST Life and Health Insurance Company, the insurance certificates are issued and the first premium is received and accepted.

Navigator's Signature:	Print Name:	Date:

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

This rider is subject to the provisions of the Group Policy and Certificate to which it is attached. It will only apply to Insureds enrolled on a BEST Life Pediatric Dental Plan.

CHILD ORTHODONTIC BENEFIT RIDER

Child Orthodontic Services.....50% Coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child.

This benefit covers Orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia includes:

(1) All procedures connected to orthodontic treatment;
(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;
(3) Periodic follow-up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;
(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.
(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of Benefits.

[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]

The Plan's deductible does not apply to this benefit.

No other provision or condition of the Group Policy or Certificate is changed in any way by this rider, except as noted above.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at 2505 McCabe Way, Irvine, California 92614.

[ ] [ ]

President **Secretary**

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

This rider is subject to the provisions of the Group Policy and Certificate to which it is attached. It will only apply to Insureds enrolled on the Plan that includes this benefit, as shown on the Schedule of Benefits.

SUPPLEMENTAL DENTAL ACCIDENT BENEFIT RIDER

Special Accident Benefit.....100% Coverage for injury to sound, natural teeth up to a Maximum Benefit of $1,000 Per Accident.

The Plan's deductible or coinsurance does not apply to this benefit.

No other provision or condition of the Group Policy or Certificate is changed in any way by this rider, except as noted above.

Signed for BEST Life and Health Insurance Company by its President and Secretary at 2505 McCabe Way, Irvine, California 92614.

[ ][ ]

President **Secretary**

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Rate Information

Rate data applies to filing.

Filing Method:	Upon Approval
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	01/01/2014
Filing Method of Last Filing:	New product

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
BEST Life and Health Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		ACTUARIAL MEMO	GFD-PPO-POL-0113TN	New		Actuarial Memorandum TN - Group July 18 2013.pdf,
2		PEDIATRIC RATE CALCULATIONS	GFD-PPO-POL-0113TN	New		Group Pediatric Rates - TN 06242013.pdf,
3		ADULT RATE CALCULATIONS	GFD-PPO-POL-0113TN	New		Group Supplemental Rates - TN 06242013.pdf,

BEST Life™
BEST Life and Health Insurance Company

Actuarial Memorandum

Responses to your questions in the Objection Letter

1 The change of policy forms will not affect rates

2 We will comply with all the applicable rules and State regulations regarding rates and benefits as prescribed in PHSA §2701, 45 CFR § 156.150, 45 CFR § 156.135 and 45 CFR § 156.130.

3 The employer will be the policyholder and coverage is renewable at the option of the policyholder.

4 See attached "Summary of Normalized Paid to Children 0-19" worksheet.

5 A revised trend factor of 3% per year is used to project costs data developed above from July 1, 2011 (mid-point of the experience period from 2010 to 2012) to July 1, 2014 (mid-point of the premium period from January 1, 2014 to December 31, 2014). As reported by the Bureau of Labor Statistics, the average annual inflation rate in the United States is 3.35% from 1914 until now but is only 2.7% from 2011 to 2012. We believe low inflation rates in the recent years will not sustain and rates will likely get back to historical level soon. Therefore, an annual trend rate of 3% is used in our projections.

6 a Average charges by procedure code are developed using our California data from 2010 to 2012

b The following standard company assumptions are applied to the average charges:
- Network use of 0.358, In-Network discount of 0.625, Out-of-Network discount of 0.767, Deductible factors of 0.9 & 0.85, Annual Maximum Limit adjustments of 0.9 and 0.95.

c Actual coinsurance percentage will be applied and the total claim cost by procedure code is determined as the sum of the average In-Network cost and the average Out-of-Network cost.

d Weighted average base cost by class is developed using national frequency by procedure code from the 2010 HealthMaps Dental Rate Manual. Costs by class are further rolled up using standard company assumptions

e. The actuarial value of the plan will be determined by comparing total net costs before and after costs sharing adjustments.

7 The net costs shown was calculated using unrounded numbers not shown. Unrounded base cost of $29.72 is $29.715027, unrounded trend of 1.09 is 1.092727 and unrounded state factor of 0.65 is 0.646098.

8 See attached Determination of Age Factor. Standard company retention of 32.25% (administration – 13.50%, premium tax – 1.75%, user fees – 3.50%, commissions – 10.00% and profit – 3.50%) is used to arrive at the target loss ratio of 67.75%.

9. See 4 & 6 above.

BEST Life™
BEST Life and Health Insurance Company

Scope and Purpose

This is a new PPO product rate filing to satisfy the Stand-Alone Supplemental and Pediatric Dental Plans Rate Filing requirements for the Tennessee Health Benefit Plan under group policy number GFD-PPO-POL-0113TN. The form filing does not replace previously approved forms.

Description of Benefits

The policies provide benefits for two small group stand-alone dental products: a Pediatric Dental Plan and a Supplemental Dental Plan. These plans will be marketed to employer groups through the Federal SHOP Exchange market. The employer will be the policyholder.

The Pediatric Dental Plan offers two plans that meet the Actuarial Value required by the Affordable Care Act. Employers who choose to purchase a stand alone dental plan will have the option to purchase from three supplemental dental plans.

Children to age 19 are eligible to enroll on the Pediatric Dental Plan. Adults and child dependents ages 19 to 26 are eligible for coverage as long as the adults are full-time employees, or part-time employees if the employer so chooses.

Benefit Renewability

The policies are standard group contracts, to be issued to employer-sponsored groups and group associations. Coverage for individuals is renewable at the option of the policyholder. The Company reserves the right to increase premiums.

Proposed Effective Date

January 1, 2014

Description of Rate Calculations

- Base claim costs are developed using our company California claims experience from 2010 to 2012.
- Base claim costs are adjusted to reflect the plan design and adjusted for area using the 2010 HealthMaps Dental Rate Manual.
- A dental trend factor of approximately 3% per year, for 3 years, is used to project future expected claims and is included in the premium rate structure
- Standard company retention of 32.25% (administration – 13.50%, premium tax – 1.75%, user fees – 3.50%, commissions – 10.00% and profit – 3.50%) is applied.
- Individual rates for the Supplemental Plans do not include premiums for the Pediatric Plans.

BEST Life™
BEST Life and Health Insurance Company

Anticipated Future Loss Ratio

The anticipated future loss ratio for this policy is expected to be 67.75%. The loss ratio is computed as follows:

$$\text{Loss Ratio} = \frac{\text{Expected Incurred Claims}}{\text{Expected Earned Premium}}$$

Incurred claims are total claims for covered expenses paid on behalf of a covered person while coverage is in force, summed for all covered persons. Earned premium is the premium for each covered person for the period coverage is in force, summed for all covered persons.

Certification

I, Adam S. Chan, Actuary for BEST Life and Health Insurance Company ("BEST"), NAIC #90638, domiciled in Texas, do hereby certify that to the best of my knowledge and judgment, this rate submission is in compliance with the applicable laws and regulations of Tennessee and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the attached rates are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory.

_____
Adam S. Chan, A.S.A., M.A.A.A.
Corporate Actuary
BEST Life and Health Insurance Company
Irvine, California

July 18, 2013
Date

BEST Life™
BEST Life and Health Insurance Company

Tennessee Health Insurance Exchange Rate Filing

Small Employer Group Dental - Essential Pediatric Plans

	High Plan - Actuarial Value 85%	Low Plan - Actuarial Value 70%
	Per Child*	Per Child*
Base Cost	$ 29.72	$ 22.60
Trend	1.09	1.09
State factor	0.65	0.65
Net Cost	$ 20.98	$ 15.96
Administrative	13.50%	13.50%
Premium Tax	1.75%	1.75%
User Fees**	3.50%	3.50%
Broker Commission	10.00%	10.00%
Profit	3.50%	3.50%
Target Loss Ratio	67.75%	67.75%
Final Rate**	$ 30.97	$ 23.55

** Children to age 19 are eligible to enroll on the Pediatric Dental Plans.*

*** User fees of 3.5% imposed by the Department of Health and Human Services are included.*

*** Apply area factors from Summary of Area Factors to determine rates by different rating areas.*

BEST Life™

BEST Life and Health Insurance Company

Tennessee Health Insurance Exchange Rate Filing

Small Employer Group Dental - Supplemental Plans

	High Plan	Mid Plan	Basic Plan
Base Cost	$ 35.32	$ 29.37	$ 22.47
Trend	1.09	1.09	1.09
State factor	0.65	0.65	0.65
Net Cost	$ 24.94	$ 20.74	$ 15.86
Administrative	13.50%	13.50%	13.50%
Premium Tax	1.75%	1.75%	1.75%
User Fees*	3.50%	3.50%	3.50%
Broker Commission	10.00%	10.00%	10.00%
Profit	3.50%	3.50%	3.50%
Target Loss Ratio	67.75%	67.75%	67.75%
Rate	$ 36.81	$ 30.61	$ 23.42

Final Rate Per Individual***

Age 19 to 26**	$ 34.45	$ 28.65	$ 21.92
Age 26 to 65	$ 36.81	$ 30.61	$ 23.42
Age 65 and Up	$ 44.17	$ 36.73	$ 28.10

** User fees of 3.5% imposed by the Department of Health and Human Services are included.*

*** Adults and child dependents ages 19 to 26 are eligible to enroll on the Supplemental Dental Plans.*

**** Apply area factors from Summary of Area Factors to determine rates by different rating areas.*

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Supporting Document Schedules

Satisfied - Item:	Cover Letter Accident & Health
Comments:	Please see General Information Description Tab for details.
Attachment(s):	
Item Status:	Approved
Status Date:	08/12/2013

Satisfied - Item:	Description of Variables
Comments:	
Attachment(s):	GFD-PPO-SOV-0113TN.pdf
Item Status:	Approved
Status Date:	08/12/2013

Bypassed - Item:	Filing Fees
Bypass Reason:	Paid by EFT.
Attachment(s):	
Item Status:	Approved
Status Date:	08/12/2013

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readability Certification_Ex.pdf
Item Status:	Approved
Status Date:	08/12/2013

Bypassed - Item:	Third Party Authorization
Bypass Reason:	N/A
Attachment(s):	

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Item Status:	Approved
Status Date:	08/12/2013

Bypassed - Item:	Group Rates Certification/Memo - Accident & Health
Bypass Reason:	Included with Actuarial Memorandum.
Attachment(s):	
Item Status:	Approved
Status Date:	08/12/2013

Bypassed - Item:	Accident & Health Group Rates non-experience
Bypass Reason:	Please see the Rate Manual included under the Rate Tab.
Attachment(s):	
Item Status:	Approved
Status Date:	08/12/2013

Satisfied - Item:	Response to Objections to Rates
Comments:	
Attachment(s):	Determination of Age Factors.pdf Summary of Area Factors - TN 06242013.pdf Summary of Normalized Paid to Children 0-19.xlsx Actuarial Memorandum TN - Group July 18 2013.pdf
Item Status:	Approved
Status Date:	08/12/2013

Satisfied - Item:	CMS Guidance on 24 month wait
Comments:	See page 2, highlighted text.
Attachment(s):	PM_FAQ10v2_508cr_052313.pdf
Item Status:	Approved
Status Date:	08/12/2013

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Satisfied - Item:	Redline
Comments:	
Attachment(s):	GFD-PPO-POL-0113TN(3) - redline.pdf
Item Status:	Approved
Status Date:	08/12/2013

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Attachment Summary of Normalized Paid to Children 0-19.xlsx is not a PDF document and cannot be reproduced here.

VARIABILITY STATEMENT

GFD-PPO-POL-0113TN

Title Page – The address of the company may change.

Page 2 – The President and Secretary of the company may change.

Page 3 – Specific to the Client.

Table of Contents – page numbers may change. The subheadings under Benefits and Exclusions will show either the Pediatric Plan provisions only or all provisions

Schedule of Benefits –

- **Policyholder** –Is bracketed to allow this product to be offered to any employer group.
- **Table of Benefits** - We are offering four "supplemental" plan designs and two pediatric dental plans. We have provided the full range of possibilities that would apply. In the final Certificate, only the plans that are selected will appear. A pediatric plan will always be shown.
- **The 80th percentile** – this is bracketed to allow either the 80th or 90th percentile to be offered.
- **Orthodontic benefits** – 24 month wait is bracketed on medically necessary orthodontia to allow no waiting period.
- **Major Dentistry Waiting Period Waiver –** Our supplemental plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate. This section does not apply to pediatric and will only appear below the Supplemental dental plan.

Part 2 Benefits and Exclusions –

- **24 Month Wait for Medically Necessary Orthodontic Benefits –** bracketed to allow for no waiting period.
- **Optional Child Orthodontic Benefits**
- We may offer child orthodontic benefits as an option depending on the size of the group. This whole section is bracketed. Only plans with this option will have this in the certificate.
- We have bracketed the option to pay benefits at 1/3 or ½ of covered benefit. We will market with 1/3, but want the option to change the benefit to ½ for new contracts.
- 12-month wait on orthodontic procedures may apply depending on group size. This statement will not appear on plans that do not have a waiting period. 12 is bracketed to allow 24 month wait.
- **Class III Major Dental Procedures** - We may offer a 12-month wait on Major Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate.
- **Implants** – We may not offer this benefit on all plans.
- **Supplemental Dental Accident Benefit** – this is bracketed in case we do not want to offer this benefit. It is also bracketed in the Schedule of Benefits.
- **Exclusions** – we have bracketed the exclusions for the Supplemental Plan. Implants has been bracketed to match the benefit offering that would or would not be available on the plan.

Effective Date for the Employee - Item #3 is bracketed and will be specific to the Client.

The Client may not want coverage effective on the date the employee qualifies.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

GFD-PPO-CERT-0113TN **Title Page** –The address of the company may change.

Page 2 – The President and Secretary of the company may change.

Statement of Coverage – Group and Insured information will be provided in the bracketed fields.

- **Subscriber Name –** Specific to individual purchasing the plan.
- **Certificate Effective Date –** Specific to the plan year for the Exchange.
- **Insured name(s) and Effective Dates(s) –** specific to client.
- **Participating Employer and Employer Number** – specific to client.
- **Plan information** – We are transitioning to a new administrative system. Our current administrative system provides plan selection information in the Statement of Coverage. The new administrative system will provide this information in the Schedule of Benefits. The Plan, Deductible, Annual Maximum, waiting period waiver is bracketed because these fields will no longer be provided once the new system is up and running.
- **Group Policy Number** – Specific to the client.

Table of Contents – page numbers may change. The subheadings under Benefits and Exclusions will show either the Pediatric Plan provisions only or all provisions

Schedule of Benefits –

- **Policyholder** – **Policyholder** –Is bracketed to allow this product to be offered to any employer group.
  - **Table of Benefits** - We are offering four "supplemental" plan designs and two pediatric dental plans. We have provided the full range of possibilities that would apply. In the final Certificate, only the plans that are selected will appear. A pediatric plan will always be shown.
  - **The 80th percentile** – this is bracketed to allow either the 80th or 90th percentile to be offered.
  - **Orthodontic benefits** – 24 month wait is bracketed on medically necessary orthodontia to allow no waiting period.
  - **Major Dentistry Waiting Period Waiver –** Our supplemental plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate. This section does not apply to pediatric and will only appear below the Supplemental dental plan.

Part 2 Benefits and Exclusions –

- **24 Month Wait for Medically Necessary Orthodontic Benefits –** bracketed to allow for no waiting period.

- Optional Child Orthodontic Benefits
  - We may offer child orthodontic benefits as an option depending on the size of the group. This whole section is bracketed. Only plans with this option will have this in the certificate.
  - We have bracketed the option to pay benefits at 1/3 or ½ of covered benefit. We will market with 1/3, but want the option to change the benefit to ½ for new contracts.
  - 12-month wait on orthodontic procedures may apply depending on group size. This statement will not appear on plans that do not have a waiting period. 12 is bracketed to allow 24 month wait
- Class III Major Dental Procedures - We may offer a 12-month wait on Major Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate.
- Implants – We may not offer this benefit on all plans.
- Supplemental Dental Accident Benefit – this is bracketed in case we do not want to offer this benefit. It is also bracketed in the Schedule of Benefits.
- Exclusions – we have bracketed the exclusions for the Supplemental Plan. Implants has been bracketed to match the benefit offering that would or would not be available on the plan.

Effective Date for the Employee - Item #3 is bracketed and will be specific to the Client. The Client may not want coverage effective on the date the employee qualifies.

General Provisions

- Notice of Claim – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

GFD-PPO-EAP-0113TN

Title of Application – plan name is bracketed.
Dental Plan Selection – the plan names are bracketed since the name may change. We are providing the full range of benefits possible within the brackets for each benefit level.
Waiting Period Waiver – We currently offer waiting period waivers for groups based on group size and if they have prior coverage. We would like to offer the same waiting period waivers if we provide waiting periods on major and orthodontic services on our Supplemental plans. This section will be taken out if no waiting periods are offered on the Supplemental dental plans.

GFD-EN-CO-0113

- Address may change.
- 12-month wait on orthodontic procedures may apply depending on group size. This statement will not appear on plans that do not have a waiting period.
- We have bracketed the option to pay benefits at 1/3 or ½ of covered benefit. We will market with 1/3, but want the option to change the benefit to ½ for new contracts. 12 is bracketed to allow for a 24 month wait.
- The Lifetime Maximum and other benefits will appear on the Schedule of Benefits. We have bracketed this in case we want this to appear elsewhere, i.e. the Statement of Coverage.
- Signatures - Officers may change.

GFD-END-SA-0113

- The address may change
- This benefit may be offered at $1,000 or $500. Only one benefit amount will appear, depending on the plan selected.
- Signatures – officers may change.

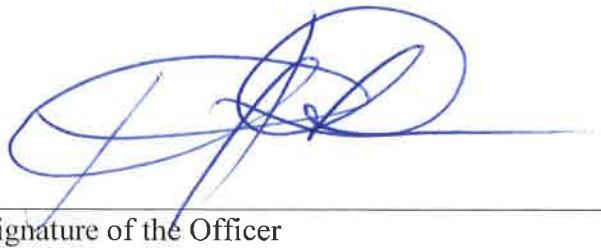
BEST Life™
BEST Life and Health Insurance Company

Readability Certification

Certification by an Officer of the Company

Persuant to TCA 56-7-1605(a)(1) and TCA 56-7-1605(e), I, Paul Peatross, am the President for the BEST Life and Health Insurance Company. I certify that the forms in this filing have been tested and meet the minimum required reading ease score.

Each form has a score of 43.5.



Signature of the Officer

4/30/2013

Date

BEST Life and Health Insurance Company

Tennessee Health Insurance Exchange Rate Filing

Determination of Age Factor for Age Band 19 to 26

Age factor from 2010 HealthMAPs Dental Manual (I-2)

under 30	2.80	2.80
30-34	2.87	
35-39	2.99	
40-44	3.00	
45-49	2.97	
50-54	3.00	
55-59	3.00	
60-64	3.10	
Average		2.99
Factor		93.6%

Determination of Age Factor for Age Band 65+

Age factor from Milliman Dental Guidelines

Average for 0-64	1.17
65+	1.40
Factor	20%

BEST Life™
BEST Life and Health Insurance Company

Tennessee Health Insurance Exchange Rate

Summary of Area Factors

	Area Factor
Rating Area 1	0.99
Rating Area 2	1.04
Rating Area 3	1.01
Rating Area 4	1.03
Rating Area 5	0.93
Rating Area 6	1.02
Rating Area 7	0.97
Rating Area 8	0.99

BEST Life™
BEST Life and Health Insurance Company

Actuarial Memorandum

Responses to your questions in the Objection Letter

1 The change of policy forms will not affect rates

2 We will comply with all the applicable rules and State regulations regarding rates and benefits as prescribed in PHSA §2701, 45 CFR § 156.150, 45 CFR § 156.135 and 45 CFR § 156.130.

3 The employer will be the policyholder and coverage is renewable at the option of the policyholder.

4 See attached "Summary of Normalized Paid to Children 0-19" worksheet.

5 A revised trend factor of 3% per year is used to project costs data developed above from July 1, 2011 (mid-point of the experience period from 2010 to 2012) to July 1, 2014 (mid-point of the premium period from January 1, 2014 to December 31, 2014). As reported by the Bureau of Labor Statistics, the average annual inflation rate in the United States is 3.35% from 1914 until now but is only 2.7% from 2011 to 2012. We believe low inflation rates in the recent years will not sustain and rates will likely get back to historical level soon. Therefore, an annual trend rate of 3% is used in our projections.

6 a Average charges by procedure code are developed using our California data from 2010 to 2012

b The following standard company assumptions are applied to the average charges:
- Network use of 0.358, In-Network discount of 0.625, Out-of-Network discount of 0.767, Deductible factors of 0.9 & 0.85, Annual Maximum Limit adjustments of 0.9 and 0.95.

c Actual coinsurance percentage will be applied and the total claim cost by procedure code is determined as the sum of the average In-Network cost and the average Out-of-Network cost.

d Weighted average base cost by class is developed using national frequency by procedure code from the 2010 HealthMaps Dental Rate Manual. Costs by class are further rolled up using standard company assumptions

e. The actuarial value of the plan will be determined by comparing total net costs before and after costs sharing adjustments.

7 The net costs shown was calculated using unrounded numbers not shown. Unrounded base cost of $29.72 is $29.715027, unrounded trend of 1.09 is 1.092727 and unrounded state factor of 0.65 is 0.646098.

8 See attached Determination of Age Factor. Standard company retention of 32.25% (administration – 13.50%, premium tax – 1.75%, user fees – 3.50%, commissions – 10.00% and profit – 3.50%) is used to arrive at the target loss ratio of 67.75%.

9. See 4 & 6 above.

BEST Life™
BEST Life and Health Insurance Company

Scope and Purpose

This is a new PPO product rate filing to satisfy the Stand-Alone Supplemental and Pediatric Dental Plans Rate Filing requirements for the Tennessee Health Benefit Plan under group policy number GFD-PPO-POL-0113TN. The form filing does not replace previously approved forms.

Description of Benefits

The policies provide benefits for two small group stand-alone dental products: a Pediatric Dental Plan and a Supplemental Dental Plan. These plans will be marketed to employer groups through the Federal SHOP Exchange market. The employer will be the policyholder.

The Pediatric Dental Plan offers two plans that meet the Actuarial Value required by the Affordable Care Act. Employers who choose to purchase a stand alone dental plan will have the option to purchase from three supplemental dental plans.

Children to age 19 are eligible to enroll on the Pediatric Dental Plan. Adults and child dependents ages 19 to 26 are eligible for coverage as long as the adults are full-time employees, or part-time employees if the employer so chooses.

Benefit Renewability

The policies are standard group contracts, to be issued to employer-sponsored groups and group associations. Coverage for individuals is renewable at the option of the policyholder. The Company reserves the right to increase premiums.

Proposed Effective Date

January 1, 2014

Description of Rate Calculations

- Base claim costs are developed using our company California claims experience from 2010 to 2012.
- Base claim costs are adjusted to reflect the plan design and adjusted for area using the 2010 HealthMaps Dental Rate Manual.
- A dental trend factor of approximately 3% per year, for 3 years, is used to project future expected claims and is included in the premium rate structure
- Standard company retention of 32.25% (administration – 13.50%, premium tax – 1.75%, user fees – 3.50%, commissions – 10.00% and profit – 3.50%) is applied.
- Individual rates for the Supplemental Plans do not include premiums for the Pediatric Plans.

BEST Life™
BEST Life and Health Insurance Company

Anticipated Future Loss Ratio

The anticipated future loss ratio for this policy is expected to be 67.75%. The loss ratio is computed as follows:

$$\text{Loss Ratio} = \frac{\text{Expected Incurred Claims}}{\text{Expected Earned Premium}}$$

Incurred claims are total claims for covered expenses paid on behalf of a covered person while coverage is in force, summed for all covered persons. Earned premium is the premium for each covered person for the period coverage is in force, summed for all covered persons.

Certification

I, Adam S. Chan, Actuary for BEST Life and Health Insurance Company ("BEST"), NAIC #90638, domiciled in Texas, do hereby certify that to the best of my knowledge and judgment, this rate submission is in compliance with the applicable laws and regulations of Tennessee and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the attached rates are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory.

_____
Adam S. Chan, A.S.A., M.A.A.A.
Corporate Actuary
BEST Life and Health Insurance Company
Irvine, California

July 18, 2013
Date

Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions

Frequently Asked Questions (FAQs) # 10
Release Date: May 9, 2013

Essential Health Benefits (EHBs)

Q1: We would like confirmation that the reasonable assurance provision in the EHB preamble applies to both individual and small group coverage.

A1: Yes, issuers of both individual and small group plans off the Exchange must be reasonably assured that enrollees have obtained pediatric dental coverage through an Exchange-certified stand-alone dental plan.

Q2: If a state discovers a clerical error or discovers an omission in the EHB template, how does the state change it? If the state wants to change a "decision" previously made about EHBs, how does the state change it?

A2: Unfortunately, the benefits, limits, and explanations representing a summary of the benchmarks that is posted on CCIIO's website (http://cciio.cms.gov/resources/data/ehb.html) cannot be changed at this time. The add-in file that populates the Plans & Benefits template is derived from this information. Please use the "EHB Variance Reason" to identify benefits as "Additional EHB Benefit" that you feel are part of the benchmark.

Q3: How much of the plan design of the benchmark transfers over to other carriers - just things listed as EHBs in the CCIIO template, things that could be categorized as EHBs by individual carriers, or all benefits (including those listed as "other" in the CCIIO template)?

A3: Any benefits and services that the benchmark plan covers are considered EHB and other carriers must be sustainably equal to the benchmark. See 45 CFR 156.115(a)(1).

Q4: Since carriers cannot substitute benefits across categories, categorization of benefits in the benchmark plan is important. What authority does the state have (or not have) to adjust categorization of benefits?

A4: Enforcing states have the authority to categorize the benefits. In the preamble to the final rule on EHB, at 78 FR 12843 we noted that states maintain flexibility in defining benefits within the 10 statutory categories.

Q5: Are pre-existing condition exclusions permitted on stand-alone pediatric dental plans?

A5: Yes. Stand-alone dental plans are not subject to Public Health Service Act § 2704 - Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status. Therefore, for the purposes of Exchange certification, CMS will not be publishing guidance on look-back periods; rather, applicable Federal and State laws apply.

Q6: Are issuers allowed to include a 24-month waiting period for orthodontia services (currently part of the FEDVIP benchmark) for both stand-alone pediatric dental and an embedded medical product that includes the pediatric dental EHB?

A6: Yes, this is permissible.

Q7: How is preventive care defined in reference to the pediatric oral Essential Health Benefit (EHB) for the purpose of applying the requirement of no cost-sharing?

A7: Pediatric oral benefits as an EHB category are defined by reference to each state's EHB-benchmark plan. A plan required to cover EHB is expected to offer benefits substantially equal to those pediatric oral benefits offered by the EHB-benchmark plan, as set forth in 45 CFR 156.115(a)(1). Preventive care must also be covered, with zero cost-sharing, but the specific preventive care services that are required to be covered are not tied to the state's EHB-benchmark, but instead to the certain preventive services as required by 45 CFR 147.130. For more information on preventive services that must be covered without cost sharing under the requirements of the Affordable Care Act, please see http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

Q8: In preamble to the EHB final rule published February 25, 2013 page 12850 made note of a safe harbor that allows for the use of single-only plans' actuarial value (AV) for the family plan equivalents if family accumulators fell within a multiplier. When will CMS offer additional guidance on the safe harbor?

A8: We do not intend to provide a multiplier at this time. Instead, in the 2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on the CCIIO website on April 5, we provide guidance on options that issuers may use to calculating a plan's AV using the AV Calculator, where the deductibles and/or out of pocket maximum costs accumulate at the family level, depending on how the deductibles and/or out of pocket maximum costs accumulate. Please see the Letter to Issuers for further clarification at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf.

Q9: Under the FEDVIP benchmark, there is a lifetime limit on orthodontia services (per child) in the amount of $3,500. During a recent call it was (we believe) concluded that this limit could be included in a stand-alone pediatric dental plan because it's an excepted benefit plan. However, in reviewing the attestations we are required to sign, and the draft CMS letter to issuers posted on March 1, it looks like this limit may be prohibited. For example, the attestations require us to attest as follows:

- **Applicant attests that all stand-alone dental plans that it offers will comply with all benefit design standards and federal regulations and laws for stand-alone dental plans, as applicable, including that:**
  a. the out-of-pocket maximum for its stand-alone dental plan is reasonable for the coverage of pediatric dental EHB;
  b. it offers the pediatric dental EHB;
  c. it does not include annual and lifetime dollar limits on the pediatric dental EHB.
- **Applicant attests that any stand-alone dental plans it offers are limited scope dental plans.**
- **Applicant attests that any stand-alone dental plans it offers will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit.**
- **Applicant attests that it either offers no stand-alone dental plans or attests to all of the above.**

Can you offer any further guidance on this? Is it permissible to include in the $3,500 lifetime max (per child) in our stand-alone pediatric dental plan?

A9: Annual and lifetime limits cannot be applied to the pediatric dental EHB, as established in 45 CFR 155.1065. Thus, to the extent that orthodontia is considered part of the pediatric dental EHB (i.e., it is medically necessary), the benefit cannot have any annual and lifetime limits.

Q10: For Exchange plans with an embedded dental benefit, is the dental carrier allowed to use different geographic area factors and/or network factors than the health plan geographic area and network factors?

A10: No, this is not permissible.

Q11: If the health plans are using the default 0-20 age band with a single age factor for children between 0-20, may the dental issuer apply separate age bands, such as 0-1, 2-10, 11-19 (children's dental only goes to age)?

A11: For the purposes of completing the application for certification of stand-alone dental plans in the FFE, stand-alone dental plans must comply with the rating rules in order to fill out the rates table and the associated business rules table, which does not permit for age banding under age 20. Note that stand-alone dental plans, as excepted benefits, have additional flexibility to adjust premiums based on other rating factors. Please see the excerpt below and pages 31-32 of the Letter to Issuers released on April 5, 2013 at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf, for additional information.

Excerpt: "To the extent that stand-alone dental plans qualify as excepted benefits, they are not required to meet the rating rules of PHS Act section 2701(a) that underlie the QHP Rating Tables and business rules template. However, stand-alone dental plans will still need to complete these tables, and based on that information, CMS will display basic, comparable rate information for stand-alone dental plans on the web portal. When a consumer is directed to the stand-alone dental plan issuer to make the initial premium payment to effectuate enrollment, the stand-alone dental plan issuers would have the ability to make any premium adjustments beyond those accounted for in the Rating Tables and based on additional rating factors available to issuers of stand-alone dental plans."

Q12: With respect to the maximum out-of-pocket (MOOP), we ask HHS to clarify that while EHB must accumulate to the MOOP, non-EHB may accumulate but are not required to. For instance, in order to design high deductible health plans (HDHPs) that are health savings account (HSA) certified, issuers would be able to accumulate all services (EHB and non-EHB) to the MOOP. In such a case, issuers would also include these non-EHB in the calculation of actuarial value (AV), which would be done outside of the AV Calculator.

A12: No. For purposes of Calculating AV, non-EHB benefits may not accumulate towards MOOP amounts. Per section 1302(a) of the Affordable Care Act, the term ''essential health benefits package'' must consist of those benefits defined under section 1302(b), limits on cost-sharing for such coverage in accordance with section 1302(c), and a package that meets applicable metal levels. Section 1302(c) contains cost sharing requirements, including MOOP limitations. Furthermore, 1302(d) on AV clarifies that the level of coverage of a plan shall be determined on the basis that the EHB.

Q13: In the preamble to the proposed rule on EHB at 77 FR 70654, HHS presents an example of a three-tiered network design and explains that the first two tiers would be considered in-network, and accumulate to the MOOP, while only the third tier would be out-of-network and not have to accumulate to the MOOP. We request, instead, that HHS permit issuers to consider the first tier as the primary in-network tier and accumulate only those costs to the OOP maximum as long as the first tier provides adequate access to providers, in compliance with network adequacy requirements. This would permit issuers to design a second tier that provides enhanced access to out-of-network providers relative to a third tier, with protections for members against significant costs from balance billing, without having to accumulate those costs to the MOOP. Requiring that these costs accumulate to the MOOP would make it unfeasible for issuers to offer members this benefit.

A13: All benefits that are in-network have to count towards EHB, regardless of network adequacy requirements and no matter how broad or narrow the benefits are.

Q14: We request clarification that issuers may have flexibility in applying the annual limitation on deductibles in the small group market or to use other types of cost sharing. For instance, issuers should be permitted to apply a deductible to only a subset of EHB, or to use fixed dollar co-pays for some services (e.g., physician office visits or prescription drugs) rather than making them subject to the deductible. Issuers could also choose not to have a deductible at all.

A14: We interpret the limits in section 1302(c)(2) of the Affordable Care Act to apply to all EHB where there is a deductible being used as a form of cost sharing. However, the QHP has the option of excluding a particular category of benefits from the deductible, which, in effect, would be having a $0 deductible for that category of benefit.

Q15: We request clarification that while EHB must apply to the AV calculation and annual limitation on cost sharing, issuers may exclude additional state-required benefits that are outside the scope of the EHB from the AV calculation. Likewise, issuers would not be required to apply these additional state-required benefits to the annual limitation on cost sharing.

A15: The AV Calculator was based on claims data from a standard population that included state mandated benefits. If the state required benefit is determined to be EHB, it should be applied to the annual cost sharing limits.

Q16: What further details can you provide on how states will reimburse issuers for benefit offer mandates (i.e., requirements to make a benefit optional through a rider) that are required to be offered in addition to the EHB?

A16: We do not consider "offer only" or "make available" mandates to be required benefits that would be subject to state payment. Although the applicable state law requires issuers to offer the coverage/rider, the law does not mandate that the issuer actually provide the benefit to all enrollees in that market.

Q17: Will states be required to defray the costs that qualified health plans (QHPs) sold outside the Marketplaces incur in meeting state benefits mandates (as they are required to do to have those mandates be required of QHPs sold through the Marketplace)?

A17: Per section 1311(d)(3) of the Affordable Care Act, as implemented by 45 CFR 155.170, if the state requires a qualified health plan (QHP) to cover additional benefits beyond EHB, the state must defray the cost. The definition of QHP is established by section 1301(a) of the Affordable Care Act and implemented in 45 CFR 155.20. This definition requires that the QHP have in effect a certification issued or recognized by each Marketplace through which such plan is offered. The requirement to defray the cost of additional benefits applies to all QHPs, including QHPs offered outside of the Marketplace.

Federal Exchange

Q18: Will issuer logos display on the FFE website?

A18: No, logos will not be displayed on the FFE website.

Q19: Do you know if/where during the FFE shopping experience shoppers will be presented with a phone number or URL to use if they have pre-enrollment questions regarding product offerings or how to enroll?

A19: A consumer can access an issuer's contact information via the link to the issuer's plan brochure. We also intend to display the issuer's contact information once a consumer has confirmed her/his plan selection.

Q20: Last I knew, the number of plans that an issuer could submit and presumably be approved and available on the FFE was not limited subject to the plans being materially differentiated in some way – can you verify (or correct) our understanding that for instance a gold plan and gold HSA qualified plan would be "different enough" for both to display as applicable in the shopping experience.

A20: As detailed in the Letter to Issuers, we provide guidance on how the FFE will review for meaningful difference for 2014:

- "First, an issuer's plans from a given state will be organized into subgroups based on plan type, metal level and overlapping counties/service areas.
- Second, CMS will review each subgroup to determine whether the potential QHPs in that subgroup differ from each other on least any one of the following criteria:
  - Different network;
  - Different formulary;
  - $50 or more difference in both individual and family in-network deductibles;
  - $100 or more difference in both individual and family in-network maximum-out-of-pocket; and
  - Difference in covered EHB.

If CMS flags a potential QHP for follow-up based on this review, we anticipate that the issuer will be given the opportunity to amend or withdraw its submission for one or more of the identified health plans. Alternatively, the issuer may submit supporting documentation to CMS explaining how the potential QHP is substantially different from others offered by the issuer for QHP certification and, thus, is in the interest of consumers to certify as a QHP. For example, an issuer may make the case that one QHP is an Accountable Care Organization. This additional information will factor into the determination of whether it is in the interest of the qualified individuals and qualified employers to certify the plan as a QHP (see 45 CFR 155.1000). CMS anticipates its approach related to meaningful difference may be updated in future years."

Exchange Forms

Q21: Is there any specific federal requirement for a company that may sell off Exchange health insurance (major med) products that it must file templates for any of the QHP certification process templates? If so, can you cite the section to help me with an explanation to the company?

A21: Specific requirements for selling off the Exchange are of the purview of the state.

Form Review

Q22: How are "optional" riders reflected in the CCIIO rate review template to differentiate what is an offer versus a rider that is embedded as required?

A22: For Rate Review only, since EHBs cannot be optional, any "optional" rider must only cover benefits in addition to EHB, and we would expect any premium and claims for such benefits to appear in the "other" categories on worksheet 2.

Additionally, all benefits offered must be benefits for which the issuer is liable for paying the claims; setting the premium; and reporting on the annual statement, MLR, and other required reporting formats as part of the issuer's claims and premium liabilities. Issuers are not allowed to report claims or premiums for "bundled" benefits, which are actually offered by another issuer but are sold in combination with or similar to a rider on their medical plan.

Q23: What clarification can HHS provide for issuers that may make mid-year formulary changes to remove drugs that are found to be unsafe or ineffective or that become available over-the-counter? Specifically, we ask that issuers not be required to add a replacement drugs to the formulary mid-year to match the number of drugs covered by the EHB benchmark plan, as long as at least one drug in the class remains covered.

A23: States will be responsible for monitoring drug lists for compliance with EHB policy as part of their review and enforcement responsibilities. Issuers will submit their drug lists to HIOS once (during the April submission period). As drug lists change, issuers are still responsible for meeting the EHB standard (the greater of one drug or the number of drugs in the state EHB benchmark plan in each USP category and class). State-based Exchanges could set their own rules in terms of requiring plans to notify the Exchange of any drug list changes or limit the frequency. Regardless, mid-year formulary changes should be infrequent. In addition to assuring formulary compliance with EHB, Exchanges should be aware of the potential for formulary discrimination.

Essential Community Providers (ECPs)

Q24: Could an issuer enter into a contract with an Essential Community Provider (ECP), requiring members to have a referral to receive in-network benefits from the ECP? In this circumstance, the ECP would not appear in the provider directory.

A24: Issuers may enter into contracts with ECPs and require members to get a referral to the ECP for non-primary care in-network benefits, to the extent that such referrals are part of the issuer's utilization management plan and program. Issuers may have such arrangements count towards the ECP inclusion standard. We are concerned, however, that the issuer might not list the ECP in the provider directory, and we discourage issuers from taking such steps that would prevent consumers from knowing whether they could access the contracted ECP. Issuers must ensure that such arrangements do not interfere with the requirement that provider networks have a sufficient number and geographic distribution of essential community providers that serve low-income and medically underserved individuals, as set forth at 45 CFR 156.235.

Cost Sharing

Q25: If a carrier has separate in- versus out-of-network out-of-pocket maximum amounts but covers services such as emergency room and ambulance from any provider, including out-of-network providers, can the services from out-of-network ambulance companies or emergency rooms accrue to the in-network out-of-pocket maximum?

A25: The general rule, as noted at 45 CFR 156.130(c), is that cost sharing for benefits provided out-of-network by a network plan do not count toward the annual limits on deductibles or maximum out-of-pocket limits. However, where the plan does not offer coverage of a particular service in network, the plan is not considered a network plan for purposes of this rule with respect to that service. Because plans are not permitted to limit coverage of emergency services set forth in 45 CFR 147.138(b) to network providers, plans are similarly not considered network plans for purposes of such services, and cost-sharing for such services received by non-network providers would apply to the out of pocket maximum.

Q26: If an indemnity plan does not have a provider network, does that plan need to comply with annual limits on deductibles or maximum out-of-pocket limits?

A26: Yes. A plan without a network must comply with the annual limits on deductibles or maximum out-of-pocket limits and cannot consider certain expenses to be non-network. The exception for non-network amounts only applies if a plan has a network (45 CFR 156.130(c)).

Stand-alone Dental Plans

Q27: What is the difference between an embedded pediatric dental benefit and a bundled pediatric dental benefit?

A27: The pediatric dental benefit is considered embedded in a medical plan when it is offered like any other benefit under same premium and included in the same AV calculation for that medical plan. Although the medical plan issuer may contract with a dental issuer to offer the pediatric dental benefit the dental benefits provided under the contract would only be considered embedded if the medical plan issuer fully assumes all risks and liabilities of covering the dental benefit. A medical plan with an embedded dental benefit provided under contract would be considered a single plan for purposes of calculating the out-of-pocket maximum and actuarial value..

Under a bundled arrangement, a medical plan issuer would pair with a stand-alone dental plan to offer the pediatric dental benefit. The issuer of each of these plans would assume the risks and liabilities associated with providing coverage under its own plan. In this situation, the medical plan and the stand-alone dental plan would each be considered a separate plan, with the stand-alone dental plan considered an excepted benefit under title XXVII of the Public Health Service Act. Accordingly, each plan would be held to applicable standards, including those related to the out-of-pocket maximum and actuarial value.

Rate Review

Q28: For rate review, how is a "new" product defined?

A28: A "new" product is one which had no previous enrollment, does not represent a previous plan with enrollment which is being modified to comply with state or federal mandates or as defined by the appropriate state regulator.

SHOP

Q29: When are the Small Business Health Options Programs (SHOPs) required to give employers the option to offer their employees more than one plan and perform premium aggregation?

A29: A11: On March 11, 2013, we published a notice of proposed rulemaking at 78 FR 15553 that would implement a transitional policy for the 2014 plan year and give SHOPs the option of postponing the employee choice model until plan years beginning on or after January 1, 2015. The FF-SHOP would take this option and postpone employee choice until January 1, 2015. State-based SHOPs could, but need not, implement this option for 2014. To align with the transitional policy, this proposed rule also postpones the requirement to perform premium aggregation to plan years beginning on or after January 1, 2015, making it optional in coverage year 2014.

Q30: What is the length of special enrollment periods in the SHOPs?

A30: In a March 11, 2013 proposed rule (78 FR 15553), we proposed aligning the length of special enrollment periods in the SHOPs with those set forth under HIPAA. Special enrollment periods in group markets, as provided for in rules implementing HIPAA, last for 30 days after loss of eligibility for other private insurance coverage or after a person becomes a dependent through marriage, birth, adoption, or placement for adoption. The proposed rule also would clarify that, consistent with HIPAA, there would be a 60-day special enrollment period for any qualified employee or dependent of a qualified employee who has become ineligible for Medicaid or CHIP or who has become eligible for state premium assistance under a Medicaid or CHIP program.

Q31: Will the geographic area premium rating factor in the small group market be based on the geographic area of the employee or that of the employer? Will this approach apply only for plans offered through the FF-SHOPs, or will it apply market-wide?

A31: A13: We intend to propose in future rulemaking that the geographic area premium rating factor must be based on the employer's primary business location in each state. This would apply both inside and outside of the SHOP. In the context of the FF-SHOPs, we intend to propose that an employer, except multi-state employers, generally may have only one SHOP account per state. Multi-state employers will still be able to establish either one SHOP account for all employees or establish multiple SHOP accounts in each state with a business location. We intend to propose that, where a multi-state employer has established an account in more than one state, the primary business location of the business in each applicable state must be used for geographic rating area purposes.

Q32: Will employers be able to enroll in the FF-SHOPs via an issuer's website in 2014?

A32: No. To ensure a smooth transition to employee choice beginning in 2015 when an employer will be able to offer multiple plan options from various issuers, enrollment through the FF-SHOP website will be the only enrollment channel available for 2014. Employee choice needs to be functional for employers renewing SHOP plan options for 2015 as of October 1, 2014, and testing needs to occur as early as early summer 2014. Thus, development of a single sign-on for employers in 2014 is the most expedient manner to transition to employee choice for 2015.

Q33: Will there be a call center supporting employers and agents/brokers working with SHOP?

A33: Yes. There will be a call center available to support employers with enrollment related matters in 2014 and beginning in 2015 for payment related matters. Agents and brokers working with employers will also be able to access the SHOP call center.

Q34: Will quarterly rate increases be allowed in the SHOP?

A34: Issuers participating in SHOP will be able to submit trend increases to their rates at the time of their original QHP application and, after that, whenever submitting new rates. We intend to propose an amendment to 45 CFR 155.705(b)(6) clarifying that, consistent with the general rules for the small group market, issuers in all SHOPs will be permitted to increase rates no more frequently than quarterly. We also intend to propose that issuers with plans offered through the FF-SHOPs will be able to submit non-trend rate updates on a quarterly basis beginning in July 2014. (As we have previously explained in guidance, it will not be possible for the FF-SHOPs to process non-trend rate changes until the third quarter of 2014.) Issuers will be notified when the FF-SHOPs begin processing non-trend quarterly rate updates. Regardless of when an employer enrolls in a plan through a SHOP, the rates applied to that employer's plan must be guaranteed for the 12 months of the plan year.

Q35: Will CMS be providing guidance related to the reconciliation process and/or the content of the monthly reconciliation file?

A35: Yes. CMS intends to publish guidance this summer that, will contain a detailed description of the enrollment reconciliation process; the content and layout of the monthly file; business logic edits the FFM will use in processing the reconciliation file; record matching criteria; a final list of the data elements to be compared in the reconciliation process; the format and content of discrepancy reports, including sample reports; and instructions for transmitting discrepancy reports to issuers and SBMs. This guidance will be relevant for issuers in both the FFM and SBMs.

Q36: Will CMS publish further updates to the 834 Enrollment Companion Guide?

A36: Yes. CMS released the Companion Guide for FFM enrollment transactions in January 2013, and we published an update in March. The current version of the Companion Guide can be found at: http://cciio.cms.gov/resources/regulations/Files/companion-guide-for-ffe-enrollment-transaction-v1.5.pdf.

Updates typically will be made when a significant technical change has been identified or a business process is modified, resulting in a change to content in a Segment or Loop. Future updates may also be made if testing reveals the need for further clarification on any of the transactions contained in the Companion Guide.

Benefits Template

Q37: We have a question on an item on the Summary of Benefits and Coverage (SBC) template. Please explain what is meant by "Abortion for Which Public Funding is Prohibited." Is that intended for states that have passed legislation prohibiting abortion coverage in QHPs sold through the Marketplace, or other legislation related to abortion?

A37: As defined in the Marketplace regulation at 45 CFR 156.280(d)(1), "abortions for which public funding is prohibited" includes those abortion services for which the expenditure of Federal funds appropriated for CMS is not permitted. More information on this topic is available at: http://www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst.

HSA Plan Variations

Q38: How should QHP issuers indicate health savings account (HSA) eligibility if the standard plan is has-eligible, but one of the cost-sharing reduction plan variations is not HSA-eligible?

A38: If a QHP issuer chooses to offer a high deductible health plan (HDHP) standard plan, with associated plan variations that are not eligible for pairing with an HSA, the QHP issuer should still select "yes" in the "HSA Eligible" field on the Plans & Benefits template.

State Mandates

Q39: If a state enacts a new requirement that issuers that provide coverage of intravenous (IV) chemotherapy must cover oral chemotherapy at parity, does the state have to defray the cost?

A39: No. We do not consider such payment parity bills to create a requirement to cover a new benefit. In addition, in the preamble to the final rule on EHB at 78 FR 12845, we stated that plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB.

Q40: If a state enacts a new requirement for applied behavioral analysis (ABA) therapy, is that a benefit in excess of EHB, or can ABA be considered EHB because it is a service specific to an EHB category (falls within habilitative or mental health including behavioral health treatment)?

A40: *Defining* habilitative services would not result in a mandate, but *requiring* specific treatments/benefits, including ABA, creates a new mandate. Below is an example of a definition of habilitative services and a mandate for services, for illustrative purposes.

Example of definition - Habilitative benefits for purposes of the state's EHB benchmark plan are defined as follows: "Habilitative services are services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in the state's EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration."

Example of mandate – A bill requires private insurance companies to provide coverage under group health insurance policies for psychiatric care; psychological care; habilitative or rehabilitative care (including ABA therapy); therapeutic; and pharmacy care to children who have been diagnosed with autism spectrum disorder (ASD).

Q41: Our state has a mandated adoption indemnity benefit that states if an insured has coverage for maternity benefits on the date of an adoptive placement, the insured's policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child's birth. This allows for a $4000 payment. We can provide that payment to the insured or apply it towards plan benefits-for example the deductible. There is no requirement to provide any specific benefits. This mandate is not included in our benchmark plan as it is a state employee plan and not subject to this state mandate. Our question is whether this benefit is considered EHB? If so, does the benefit dollar limit have to be removed?

A41: As stated in the preamble to the final rule on EHB at 78 FR 12838, we interpret ''state-required benefits'' to include the care, treatment and services that an issuer must provide to its enrollees. Other state laws that do not relate to specific benefits, including those relating to providers and benefit delivery method, are not considered state-required benefits. In this case, there is no requirement to cover a specific benefit. The issuer is required to pay a certain amount to the insured and the insured can use that money in any way. The requirement does not pertain to health services and would not fit into any of the 10 EHB categories. Therefore, it is not EHB and the prohibition on dollar limits and the requirement to defray the cost would not apply.

Grace Periods

Q42: 45 CFR 156.270(d) provides for a grace period of three consecutive months for QHP enrollees who receive APTC. Section 156.270(d)(1) states that an issuer must pay all appropriate claims for services in the first month of the grace period and may pend claims for services in the second and third months of the grace period. Under HIPAA regulations regarding administrative simplification requirements for electronic transactions and code sets, 45 CFR Part 162, providers are required to use the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standards, Version D, Release 0, when billing pharmacy claims. This standard does not contain a transaction allowing a claim to be pended. How should issuers handle pharmacy claims in months two and three of the grace period?

A42: 45 CFR 156.270(d) does not require issuers to pay claims during months two and three of the grace period. Thus, issuers may pend these claims. However, issuers may not be able to pend pharmacy claims, only pay or deny such claims. In such instances, where it is not possible for the issuer to pend the claim, the issuer may deny the claim. If an enrollee pays for a drug out-of-pocket during the second or third months of the grace period due to an issuer's denial of the claim and subsequently pays his or her share of the premium so as to no longer be in the grace period, that enrollee may submit a receipt, and the issuer must reimburse its share of the cost directly to the enrollee. Thus, the enrollee can be made whole even if a claim cannot technically be pended.

Q43: 45 CFR 156.270(d) provides for a grace period of three consecutive months for QHP enrollees who receive APTC. Section 156.270(d)(1) states that an issuer must pay all appropriate claims for services in the first month of the grace period and may pend claims for services in the second and third months of the grace period. If a QHP provides for the dispensing of a 90-day supply of drugs, does a QHP issuer have to provide the full 90-day supply if an enrollee is in the first month of the grace period?

A43: Yes, the issuer should provide the full 90-day supply, pursuant to 45 CFR 156.270(d).

Risk Corridor

Q44: Will offering the identical benefit plan under two separate HIOS Product IDs on and off the Exchange preclude participation in the risk corridor program?

A44: Section 1342 of the Affordable Care Act directs HHS to establish a temporary risk corridors program during the years 2014 through 2016 and requires that all Issuers of qualified health plans in the individual and small group markets to participate. We are currently working on the risk corridors program. The approach of establishing separate product IDs for QHPs on and off the Exchange would not preclude the QHPs off the Exchange from participating in the risk corridors program. As we continue our work, we will consult with stakeholders to ensure that we provide sufficient flexibility.

Group Insurance Policy

Dental PPO Plan

BEST Life™

BEST Life and Health Insurance Company

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Policy provides dental coverage only.

GFD-PPO-POL-0113TN

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers ~~to the Group Policyholder~~ and any other ~~their e~~Eligible Persons~~Dependents~~ under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: ABC Company

Group Policy Effective Date: [XX-XX-XXXX]

Group Policy Number: [XXX]

State of Delivery: Tennessee

Premiums Due On: 1st of each month

First Renewal Date: [XX-XX-XXXX]

[Intentionally Blank Page]

TABLE OF CONTENTS

Formatt

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at ~~the [80th or 90th] percentile of a~~ a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

[

	[BEST Life Child Dental] [Plus] High Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible[– Applies to Class I ~~Preventive[,]~~ S[~~s~~ervices received Out-of-Network as well as~~]~~ Class II and III Services~~Basic and Major services~~ received In-Network or Out-of-Network]	$~~[~~0~~][50]~~	$[50~~][100]~~
Class I – Basic Services Coinsurance[~~**Diagnostic & Preventive Services Coinsurance**~~ – Exams,	100%	~~[~~90~~][60]~~%
Class II - Intermediate~~Basic~~ Services Coinsurance[– Fillings]	~~[~~70~~][55]~~%	~~[~~60~~][40]~~%
Class III - Major Services Coinsurance[– Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	~~[~~50~~][35]~~%	~~[~~40~~][20]~~%
Class IV Medically Necessary Orthodontic Services Coinsurance ~~(Medically necessary Orthodontic~~	50% [24 Month Wait]	50% [24 Month Wait]

]

[

	[BEST Life Child Dental] Low Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible[– Applies to Class I, II and III Services received In-Network or Out-of-Network]	$50	$100
Class I – Basic Services Coinsurance[– Exams, cleanings, sealants, fluoride treatment, x-rays]	100%	60%
Class II - Intermediate Services Coinsurance[– Fillings]	55%	40%
Class III - Major Services Coinsurance[– Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	35%	20%
Class IV – Medically Necessary Orthodontic Services Coinsurance	50% [24 Month Wait]	50% [24 Month Wait]

]

~~[Dental Plan Schedule of Benefits~~
~~For Adults and Dependent Children between 19 and 26]~~

	~~[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan~~	
~~**Benefits Description**~~	~~**In-Network [Network]**~~	~~**Out-of-Network**~~
~~**Employer Contributory or Voluntary**~~	~~[Employer contributory][Voluntary]~~	
~~**Annual Maximum**~~	~~$[750 – 2,500]~~	
~~**Annual Deductible**~~ ~~(Applies to Basic and Major) – 3 Deductible Maximum per Family~~	~~[$0-100]~~	
~~**Preventive Care Services**~~ ~~Routine oral exam, cleanings, X-rays~~	~~100%~~	~~[100-70]%~~
~~**Basic Services**~~ ~~Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology~~	~~[90-50]%~~	~~[80-20]%~~
~~**Major Services**~~ ~~Crowns & gold fillings, inlays, onlays & ponties, [implants,] fixed bridges, complete & partial dentures, oral surgery~~	~~[60-0]%~~	~~[50-0]%~~
~~**[Major Services Waiting Period**~~	~~12 Months]~~	
~~**Endodontic Services**~~	~~[Basic][Major]~~	
~~**Periodontic Services**~~	~~[Basic][Major]~~	

Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt
Formatt control
Formatt

[Dental Accident Benefit	$1,000]	
Usual and Customary Reimbursement	Fee Schedule	[70th – 95th] Percentile

]

[Major Dentistry Waiting Period Waiver

The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Basic Preventive and Diagnostic Procedures ServicesInclude:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Intermediate ServicesBasic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;
    f. tooth reimplantation;
    g. surgical access of unerupted tooth;
    h. alveoloplasty;
    i. removal of exostosis;
    j. incision and drainage of abscess;
    k. suture of recent small wounds up to five (5) cm
    l. excision of pericoronal gingival;

Class III – Major S~~P~~rocedures ervices~~Include~~:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;

(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

~~[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]~~

Class IV – Medically Necessary Orthodontic ~~Procedures~~ Services [Note: Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]~~Include~~:

Formatt

(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

~~**[Optional Child Orthodontic Benefit**~~
~~This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:~~

~~(1) All procedures connected to orthodontic treatment at 50% coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child;~~
~~(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;~~
~~(3) Periodic follow up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;~~
~~(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.~~
~~(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of Benefits.~~

~~[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]~~

~~The Plan's deductible does not apply to this benefit.]~~

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a

felony;

(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;

(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;

(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;

(7) Space maintainers;

(8) Sealants if re-sealed within a five (5) year period;

(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;

(10) Elective tooth extractions;

(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;

(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;

(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;

(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);

(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;

(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;

(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);

(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;

(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;

(20) Services not completed on or before the date of termination;

(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;

(22) Expenses that are applied toward satisfaction of a Deductible, if any;

(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;

(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;

(25) Chemotherapeutic agents and any other experimental procedures;

(26) Expenses incurred for veneers and related procedures;

(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere

in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
    (a) root recovery (surgical removal of residual root);
    (b) oral antral fistula closure;
    (c) removal of a dentigerous or odontogenic cyst;
    (d) incision and drainage of an abscess;
    (e) removal of lateral exostosis;
    (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required

because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;

(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
   (a) accidental injury requiring oral surgical treatment, or
   (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.

(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
   (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
   (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;

(6) Repair or reline of dentures and bridgework[;

(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
   (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
   (b) implant supported prosthetics;
   (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
   (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
   (e) implant maintenance].

~~**[Supplemental Dental Accident Benefit**~~

~~This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.]~~

~~EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN~~

~~The following exclusions are not Covered Services. No payments will be made by Us for these services:~~

~~(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;~~

~~(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;~~

~~(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;~~

~~(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;~~

~~(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was~~

opened before the patient was covered;

(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;

(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;

(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;

(9) Implants, implant services and implant supported prosthetics[are not covered for patients under the age of sixteen (16)];

(10) Expenses incurred for veneers and related procedures;

(11) Replacement of a lost or stolen or discarded prosthetic device;

(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;

(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;

(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;

(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;

(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;

(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;

(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;

(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;

(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;

(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);

(22) Expenses incurred for congenital or developmental malformations;

(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);

(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;

(25) Chemotherapeutic agents and any other experimental procedures;

(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;

(27) Expenses that are applied toward satisfaction of a Deductible, if any;

(28) Services and supplies performed outside of the United States of America;

(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step parent, grandparent, brother, sister, cousin or in-law;

(30) Expenses for services for which You would not legally have to pay if there were no insurance;

~~(31) Services not completed on or before the date of termination;~~
~~(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;~~
~~(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;~~
~~(34) Expenses incurred for services covered on a pediatric only dental plan.]~~

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;

(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, 2 or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

~~ORTHODONTIC TREATMENT IN PROGRESS~~

~~BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.~~

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A dependent child who meets the definition of Eligible Person may be enrolled and covered under this Policy, as follows:

1. A child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that child is nineteen (19) years of age on the renewal date;
2. A child who is older than nineteen (19) years of age on the coverage effective date or renewal date may be covered under the Supplemental Family Dental Insurance, if Supplemental Family Dental Insurance is endorsed onto the policy.

~~Child: A person under the age of twenty six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:~~

~~1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;~~

~~2. A Child who is between nineteen (19) and twenty six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.~~

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Dependent: An Eligible Person, other than the Eligible Employee, and who is enrolled in and covered under this policy of insurance.

Covered Employee; An Eligible Employee who is enrolled in and covered under this Policy of insurance.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Person:

(1) You [to age 65]
(2) Your lawful spouse or domestic partner [to age 65]; and
(3) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are less than twenty-six (26) years of age; or
(4) A child named in a Qualified Medical Child Support Order will be considered an Eligible Person.

"Eligible Person" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for

dependent insurance under this Policy.
~~Eligible Dependent: Means:~~
~~(1) Your lawful spouse or domestic partner and~~
~~(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or~~
~~(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.~~

~~"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.~~

Eligible Employee: Means:
(1) A full-time permanent employee who is:
  (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
  (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or
(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

~~**Grace Period:** A Grace Period of thirty one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.~~

Insured: ~~The~~ An ~~Subscriber or any~~ Eligible ~~Dependent~~ Person ~~of a Subscriber~~ who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Pocket Maximum: The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

~~**Subscriber:**~~

~~(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or~~

~~(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full time basis.~~

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the ~~Subscriber~~Eligible Employee or Covered Employee.

PART 5 – ENROLLMENT, EFFECTIVE DATE AND TERMINATION DATE

ENROLLMENT

An Eligible Employee must:

(1) Enroll all existing Eligible Persons in accordance with the annual open enrollment period requirements;

(2) Enroll all Eligible Persons within thirty (30) days of one of the following triggering events:

- (a) The date on which an Eligible Person loses minimum essential coverage;
- (b) An Eligible Employee adds a new Eligible Person to the family;
- (c) A person becomes an Eligible Person through marriage, birth, adoption or placement for adoption;
- (d) An Eligible Person's enrollment or non-enrollment in a qualified health plan is

unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

(e) An enrollee adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(f) An Eligible Person gains access to new qualified health plans as a result of a permanent move;

(g) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and

(h) An Eligible Person demonstrates that they qualify because of other exceptional circumstances.

EFFECTIVE DATE

Your insurance will become in effect as follows:

(1) If enrollment is received between the first (1st) and the fifteenth (15th) day of the enrollment period, coverage will be effective on the first day of the following month; and

(2) If enrollment is received between the sixteenth (16th) and the last day of the enrollment period, coverage will be effective on the first day of the second following month.

TERMINATION DATE

Coverage may be terminated, as follows:

(1) You may terminate coverage with appropriate notice.

(2) We may terminate coverage in the following circumstances:

(a) You are no longer eligible for coverage through the Exchange;

(b) Non-payment of premiums;

(c) Your coverage is rescinded;

(d) We terminate or decertify; or

(e) You change insurance carriers during an annual open enrollment period or special enrollment period.

~~**PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES**~~

~~**EFFECTIVE DATE**~~

~~**Employee:** If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:~~

~~(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty one (31) days of that date; or~~

~~(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty one (31) days after You satisfy the waiting period[; or~~

~~(3) the date You become a qualified employee.]~~

~~If Your enrollment card is received by Us more than thirty one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.~~

~~During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of~~

$500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full time employment.

Dependent: Your Dependent's insurance will take effect on the later of:

(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or

(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;

(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;

(3) the date Insured ceases to be in a class eligible for insurance under this plan;

(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;

(5) the day before the due date of any premium that remains unpaid at the end of the grace period;

(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. ~~During the Grace Period, this Group Policy will remain in force.~~ If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the last date paid in full ~~Grace Period~~.

Termination of Group Policy: [This Group Policy will terminate if: (1) the Group Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status.] We may terminate this Group Policy[at any time following the first renewal date]by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this

Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied

on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be

inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
(A) the due date to pay any required premium (if premium is not paid by that date).
(B) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
(C) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
~~I.~~ a date which is:
(D)
~~II.~~ 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
I.
~~III.~~II. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

Formatt
Formatt
Left + 1
Formatt
Left + 1

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact [BEST Life's Customer Service at {1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to [BEST Life and Health Insurance Company, Attn: Appeals, {P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 10 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

[ENDORSEMENT - SUPPLEMENTAL FAMILY DENTAL INSURANCE

If the Policyholder selected Family Dental Coverage, then this Endorsement modifies, supplements, and becomes a part of the Certificate for Covered Persons over the age of 18 years. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

Dental Plan Schedule of Benefits
For Eligible Persons over 18 years

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible [(Applies to Basic and Major) – 3 Deductible Maximum per Family]	[$0-100]	
Preventive Care Services [Routine oral exam, cleanings, X-rays]	100%	[100-70]%
Basic Services [Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology]	[90-50]%	[80-20]%
Major Services [Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery]	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
[Endodontic Services	[Basic][Major]]	
[Periodontic Services	[Basic][Major]]	

COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS A – Basic Services:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS B – Intermediate Services:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;

(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
(a) erupted tooth;
(b) soft tissue impaction;
(c) partial bony impaction;
(d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
(a) root recovery (surgical removal of residual root);
(b) oral antral fistula closure;
(c) removal of a dentigerous or odontogenic cyst;
(d) incision and drainage of an abscess;
(e) removal of lateral exostosis;
(f) frenulectomy.

CLASS C - Major Services: [Employer groups without continuous, prior coverage for the twelve (12) month period prior to enrolling with Us will have a twelve (12) month Waiting Period before this Policy covers Major dental services.] Major Dental Services are as follows:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
(a) accidental injury requiring oral surgical treatment, or
(b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
(a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
(b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non- chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
(a) the surgical placement of endosteal implant body including healing cap, where the bone

Formatt
Formatt
Formatt

and soft tissues are sound and healthy;
(b) implant supported prosthetics;
(c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
(d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
(e) implant maintenance.]

[ENDORSEMENT – ORTHODONTIC SERVICES

If the Policyholder selected Orthodontic Coverage, then this Endorsement modifies, supplements, and becomes a part of the Certificate for Covered Persons up to the age of 19 years. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

Optional Child Orthodontic Benefit

This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

Schedule of Orthodontic Benefits

Benefit Description	In Network	Out-of-Network
Orthodontic Coinsurance	50%	50%
Calendar Year Maximum	$500	$500
Lifetime Maximum	$1000	$1000

The initial services may be no greater than [1/3][1/2] of the Lifetime Maximum Benefit Amount; thereafter, follow-up visits will be paid equally on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;

Termination of Coverage

Benefits end once braces are removed or when coverage is cancelled, whichever is first.

[Waiting Period

A 12-Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the 12-Month Waiting Period immediately following the effective date of this Plan.]

[Deductible

The Plan's deductible does not apply to this benefit.]]

Exclusion

(1) Medically necessary orthodontic services.

(2) Orthodontic Services for Insureds who are over 18 years of age.

Underwritten by BEST Life and Health Insurance Company]

~~Underwritten by BEST Life and Health Insurance Company~~

Formatt
3.8 pt

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/31/2013	Replaced 08/12/2013	Form	GROUP POLICY	08/09/2013	GFD-PPO-POL-0113TN(2).pdf (Superceded)
07/31/2013	Replaced 08/12/2013	Supporting Document	Redline	08/09/2013	GFD-PPO-POL-0113TN(2)-redline.pdf (Superceded)
07/26/2013	Replaced 08/12/2013	Form	GROUP POLICY	07/31/2013	GFD-PPO-POL-0113TN.pdf (Superceded) GFD-PPO-POL-0113TN_redline.pdf (Superceded)
07/26/2013	Replaced 08/12/2013	Form	CERTIFICATE	08/09/2013	GFD-PPO-CERT-0113TN.pdf (Superceded) GFD-PPO-CERT-0113TN_redline.pdf (Superceded)
07/18/2013	Replaced 08/12/2013	Rate	ACTUARIAL MEMO	07/26/2013	Actuarial Memorandum TN - Group July 18 2013.pdf
07/18/2013	Replaced 08/12/2013	Rate	PEDIATRIC RATE CALCULATIONS	07/26/2013	Group Pediatric Rates - TN 06242013.pdf
07/18/2013	Replaced 08/12/2013	Rate	ADULT RATE CALCULATIONS	07/26/2013	Group Supplemental Rates - TN 06242013.pdf
07/18/2013	Replaced 08/12/2013	Supporting Document	Response to Objections to Rates	07/26/2013	Determination of Age Factors.pdf Summary of Area Factors - TN 06242013.pdf Summary of Normalized Paid to Children 0-19.xlsx

SERFF Tracking #: BLHI-129004056 **State Tracking #:** H-130558 **Company Tracking #:** FORM FILING

State: Tennessee **Filing Company:** BEST Life and Health Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Stand Alone Dental
Project Name/Number: Form Filing/Exchange Products

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/13/2013	Replaced 08/12/2013	Form	GROUP POLICY	07/26/2013	GFD-PPO-POL-0113TN.pdf (Superceded) GAD-PPO-POL-0113TN_redline.pdf (Superceded)
06/13/2013	Replaced 08/12/2013	Form	CERTIFICATE	07/26/2013	GFD-PPO-CERT-0113TN.pdf (Superceded) GAD-PPO-CERT-0113TN_redline.pdf (Superceded)
06/13/2013	Replaced 08/12/2013	Form	VARIABILITY STATEMENT	07/26/2013	GFD-PPO-SOV-0113TN.pdf (Superceded)
04/30/2013	Replaced 08/12/2013	Rate	ACTUARIAL MEMO	07/18/2013	Actuarial Memorandum TN - Group April 30 2013.pdf (Superceded)
04/30/2013	Replaced 08/12/2013	Rate	PEDIATRIC RATE CALCULATIONS	07/18/2013	Group Pediatric - TN 04302013.pdf (Superceded)
04/30/2013	Replaced 08/12/2013	Rate	ADULT RATE CALCULATIONS	07/18/2013	Group Supplemental - TN 04302013.pdf (Superceded)
04/30/2013	Replaced 08/12/2013	Form	GROUP POLICY	06/13/2013	GAD-PPO-POL-0113TN.pdf (Superceded)
04/30/2013	Replaced 08/12/2013	Form	CERTIFICATE	06/13/2013	GAD-PPO-CERT-0113TN.pdf (Superceded)
04/30/2013	Replaced 08/12/2013	Form	VARIABILITY STATEMENT	06/13/2013	GAD-PPO-SOV-0113TN.pdf (Superceded)
04/30/2013	Replaced 08/12/2013	Form	GROUP POLICY	06/13/2013	GPD-PPO-POL-0113TN.pdf (Superceded)
04/30/2013	Replaced 08/12/2013	Form	CERTIFICATE	06/13/2013	GPD-PPO-CERT-0113TN.pdf (Superceded)

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/30/2013	Replaced 08/12/2013	Form	VARIABILITY STATEMENT	06/13/2013	GPD-PPO-SOV-0113TN.pdf (Superceded)
04/30/2013	Replaced 08/12/2013	Form	EMPLOYER APPLICATION	06/13/2013	GAD-PPO-EAPP-0113TN.pdf (Superceded)
04/27/2013	Replaced 08/12/2013	Supporting Document	Description of Variables	06/13/2013	

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: ABC Company

Group Policy Effective Date: [XX-XX-XXXX]

Group Policy Number: [XXX]

State of Delivery: Tennessee

Premiums Due On: 1st of each month

First Renewal Date: [XX-XX-XXXX]

[Intentionally Blank Page]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

	[BEST Life Child Dental] [Plus] Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	$[0][200]	$[50][200]
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
Basic Services Coinsurance – Fillings	70%	[60][40]%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	50%	[40][20]%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;

b. surgical removal of erupted tooth;
c. removal of impacted tooth;
d. removal of residual tooth roots;
e. coronectomy;
f. tooth reimplantation;
g. surgical access of unerupted tooth;
h. alveoloplasty;
i. removal of exostosis;
j. incision and drainage of abscess;
k. suture of recent small wounds up to five (5) cm
l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

Class IV – Medically Necessary Orthodontic Services [**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]**:**

(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical

dentistry or a doctor of dental surgery, or a denturist;

(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;

(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;

(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;

(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;

(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;

(7) Space maintainers;

(8) Sealants if re-sealed within a five (5) year period;

(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;

(10) Elective tooth extractions;

(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;

(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;

(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the “Schedule of Benefits” section of this Plan, or in excess of the Preferred Provider Fee Schedule;

(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);

(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;

(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;

(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);

(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient’s lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;

(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;

(20) Services not completed on or before the date of termination;

(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;

(22) Expenses that are applied toward satisfaction of a Deductible, if any;

(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;

(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;

(25) Chemotherapeutic agents and any other experimental procedures;

(26) Expenses incurred for veneers and related procedures;

(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
    (a) root recovery (surgical removal of residual root);
    (b) oral antral fistula closure;
    (c) removal of a dentigerous or odontogenic cyst;
    (d) incision and drainage of an abscess;
    (e) removal of lateral exostosis;
    (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
    (a) accidental injury requiring oral surgical treatment, or
    (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
    (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
    (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
    (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
    (b) implant supported prosthetics;
    (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
    (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
    (e) implant maintenance].

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;
(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, 2 or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If

the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A dependent child who meets the definition of Eligible Person may be enrolled and covered under this Policy, as follows:

1. A child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that child is nineteen (19) years of age on the renewal date;
2. A child who is older than nineteen (19) years of age on the coverage effective date or renewal date may be covered under the Supplemental Family Dental Insurance, if Supplemental Family Dental Insurance is endorsed onto the policy.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Dependent: A Child who is an Eligible Person and who is enrolled in and covered under an active policy of insurance issued to the Subscriber named on the Statement of Coverage.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Person:

(1) You [to age 65]
(2) Your lawful spouse or domestic partner [to age 65]; and
(3) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are less than twenty-six (26) years of age; or
(4) A child named in a Qualified Medical Child Support Order will be considered an Eligible Person.

"Eligible Person" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this

plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
   (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
   (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or

(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Pocket Maximum: The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 5 – ENROLLMENT, EFFECTIVE DATE AND TERMINATION DATE

ENROLLMENT

An Eligible Employee must:

(1) Enroll the Eligible Employee and any Eligible Dependents in accordance with the annual open enrollment period;

(2) Enroll the Eligible Employee and any Eligible Dependents within thirty (30) days of one of the following triggering events:

- (a) The date on which an Eligible Employee or Eligible Dependent loses minimum essential coverage;
- (b) An Eligible Employee gains an Eligible Dependent;
- (c) A dependent becomes an Eligible Dependent through marriage, birth, adoption or placement for adoption;
- (d) An Eligible Employee or Eligible Dependent's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- (e) An enrollee adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- (f) An Eligible Employee or Eligible Dependent gains access to new qualified health plans as a result of a permanent move;

(g) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
(h) An Eligible Employee or Eligible Dependent demonstrates that the individual meets other exceptional circumstances.

EFFECTIVE DATE
Your insurance will become in effect as follows:
(1) If enrollment is received between the first (1st) and the fifteenth (15th) day of the enrollment period, coverage will be effective on the first day of the following month; and
(2) If enrollment is received between the sixteenth (16th) and the last day of the enrollment period, coverage will be effective on the first day of the second following month.

TERMINATION DATE
Coverage may be terminated, as follows:
(1) You may terminate coverage with appropriate notice.
(2) We may terminate coverage in the following circumstances:
(a) You are no longer eligible for coverage through the Exchange;
(b) Non-payment of premiums;
(c) Your coverage is rescinded;
(d) We terminate or decertify; or
(e) You change insurance carriers during an annual open enrollment period or special enrollment period.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the last date paid in full .

Termination of Group Policy: [This Group Policy will terminate if: (1) the Group Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status.] We may terminate this Group Policy[at any time following the first renewal date]by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an

application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific

description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (A) the due date to pay any required premium (if premium is not paid by that date).
    (B) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (C) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (D) a date which is:
        I. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        II. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact [BEST Life's Customer Service at

1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to [BEST Life and Health Insurance Company, Attn: Appeals, P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 10 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

[ENDORSEMENT - SUPPLEMENTAL FAMILY DENTAL INSURANCE

If the Policyholder selected Family Dental Coverage, then this Endorsement modifies, supplements, and becomes a part of the Certificate for Covered Employees and their Covered Dependents over the age of 18 years. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

Dental Plan Schedule of Benefits
For Eligible Persons over 19 years

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible [(Applies to Basic and Major) – 3 Deductible Maximum per Family]	[$0-100]	
Preventive Care Services [Routine oral exam, cleanings, X-rays]	100%	[100-70]%
Basic Services [Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology]	[90-50]%	[80-20]%
Major Services [Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery]	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
[Endodontic Services	[Basic][Major]]	
[Periodontic Services	[Basic][Major]]	

COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS A – Basic Services:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS B – Intermediate Services:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a

Covered Dental Expense on this Plan;

(6) Surgical extraction, including impaction:
   (a) erupted tooth;
   (b) soft tissue impaction;
   (c) partial bony impaction;
   (d) complete bony impaction;

(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);

(8) Periodontics (tissues and gums);

(9) Periodontal exam (not in addition to a routine oral exam);

(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;

(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);

(12) Endodontics (pulp capping and root canal); and

(13) Oral surgery:
   (a) root recovery (surgical removal of residual root);
   (b) oral antral fistula closure;
   (c) removal of a dentigerous or odontogenic cyst;
   (d) incision and drainage of an abscess;
   (e) removal of lateral exostosis;
   (f) frenulectomy.

CLASS C - Major Services: [Employer groups without continuous, prior coverage for the twelve (12) month period prior to enrolling with Us will have a twelve (12) month Waiting Period before this Policy covers Major dental services.] Major Dental Services are as follows:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);

(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;

(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;

(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
   (a) accidental injury requiring oral surgical treatment, or
   (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.

(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
   (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
   (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non- chewing injury while covered;

(6) Repair or reline of dentures and bridgework[;

(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
   (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;

(b) implant supported prosthetics;
(c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
(d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
(e) implant maintenance.]

[ENDORSEMENT – ORTHODONTIC SERVICES

If the Policyholder selected Orthodontic Coverage, then this Endorsement modifies, supplements, and becomes a part of the Certificate for Covered Employees and their Covered Dependents up to the age of 19 years. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

Optional Child Orthodontic Benefit

This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

Schedule of Orthodontic Benefits

Benefit Description	In Network	Out-of-Network
Orthodontic Coinsurance	50%	50%
Calendar Year Maximum	$500	$500
Lifetime Maximum	$1000	$1000

The initial services may be no greater than [1/3][1/2] of the Lifetime Maximum Benefit Amount; thereafter, follow-up visits will be paid equally on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;

Termination of Coverage

Benefits end once braces are removed or when coverage is cancelled, whichever is first.

[Waiting Period

A 12-Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the 12-Month Waiting Period immediately following the effective date of this Plan.]

[Deductible

The Plan's deductible does not apply to this benefit.]]

Exclusion

(1) Medically necessary orthodontic services.
(2) Orthodontic Services for Insureds who are over 18 years of age.

Underwritten by BEST Life and Health Insurance Company]

Group Insurance Policy

Dental PPO Plan

BEST Life™

BEST Life and Health Insurance Company

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Policy provides dental coverage only.

GFD-PPO-POL-0113TN

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: ABC Company

Group Policy Effective Date: [XX-XX-XXXX]

Group Policy Number: [XXX]

State of Delivery: Tennessee

Premiums Due On: 1st of each month

First Renewal Date: [XX-XX-XXXX]

[Intentionally Blank Page]

TABLE OF CONTENTS

Formatt

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

	[BEST Life Child Dental] [Plus] Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	$[0][20~~[~~0]~~][50]~~	$[50][2~~1~~00]
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
Basic Services Coinsurance – Fillings	~~[~~70~~][55]~~%	[60][40]%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	~~[~~50~~][35]~~%	[40][20]%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

[Dental Plan Schedule of Benefits
For Adults and Dependent Children between 19 and 26]

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	In-Network [Network]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	[$0-100]	
Preventive Care Services Routine oral exam, cleanings, X rays	100%	[100-70]%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
Major Services Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
Endodontic Services	[Basic][Major]	
Periodontic Services	[Basic][Major]	
[Dental Accident Benefit	$1,000]	
Usual and Customary Reimbursement	Fee Schedule	[70th – 95th] Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON

PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;

e. coronectomy;
f. tooth reimplantation;
g. surgical access of unerupted tooth;
h. alveoloplasty;
i. removal of exostosis;
j. incision and drainage of abscess;
k. suture of recent small wounds up to five (5) cm
l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

~~[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]~~

Class IV – Medically Necessary Orthodontic ~~Procedures~~ Services [**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]~~Include~~**:**

Formatt

(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

~~**[Optional Child Orthodontic Benefit**~~
~~This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:~~

~~(1) All procedures connected to orthodontic treatment at 50% coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child;~~

(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;
(3) Periodic follow up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;
(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.
(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of Benefits.

[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]

The Plan's deductible does not apply to this benefit.]

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;

(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
  (a) erupted tooth;
  (b) soft tissue impaction;
  (c) partial bony impaction;
  (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures

(partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
  (a) root recovery (surgical removal of residual root);
  (b) oral antral fistula closure;
  (c) removal of a dentigerous or odontogenic cyst;
  (d) incision and drainage of an abscess;
  (e) removal of lateral exostosis;
  (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  (a) accidental injury requiring oral surgical treatment, or
  (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  (b) implant supported prosthetics;
  (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  (e) implant maintenance].

[Supplemental Dental Accident Benefit

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.]

EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics[are not covered for patients under the age of sixteen (16)];
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;
(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;

(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.]

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;
(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, 2 or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

~~ORTHODONTIC TREATMENT IN PROGRESS~~

~~BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.~~

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A dependent child who meets the definition of Eligible Person may be enrolled and covered under this Policy, as follows:

1. A child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that child is nineteen (19) years of age on the renewal date;
2. A child who is older than nineteen (19) years of age on the coverage effective date or renewal date may be covered under the Supplemental Family Dental Insurance, if Supplemental Family Dental Insurance is endorsed onto the policy.

~~Child: A person under the age of twenty six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:~~

~~1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;~~

~~2. A Child who is between nineteen (19) and twenty six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.~~

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is

satisfied.

Covered Dependent: A Child who is an Eligible Person and who is enrolled in and covered under an active policy of insurance issued to the Subscriber named on the Statement of Coverage.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Person:

(1) You [to age 65]
(2) Your lawful spouse or domestic partner [to age 65]; and
(3) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are less than twenty-six (26) years of age; or
(4) A child named in a Qualified Medical Child Support Order will be considered an Eligible Person.

Formatt

"Eligible Person" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

~~Eligible Dependent: Means:~~

~~(1) Your lawful spouse or domestic partner and~~
~~(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or~~
~~(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.~~

~~"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.~~

Formatt

Eligible Employee: Means:

(1) A full-time permanent employee who is:
   (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
   (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or
(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period~~;~~ provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Pocket Maximum: The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

Formatt

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 5 – ENROLLMENT, EFFECTIVE DATE AND TERMINATION DATE

ENROLLMENT

An Eligible Employee must:

(1) Enroll the Eligible Employee and any Eligible Dependents in accordance with the annual open enrollment period;

(2) Enroll the Eligible Employee and any Eligible Dependents within thirty (30) days of one of the following triggering events:

(a) The date on which an Eligible Employee or Eligible Dependent loses minimum essential coverage;

(b) An Eligible Employee gains an Eligible Dependent;

(c) A dependent becomes an Eligible Dependent through marriage, birth, adoption or placement for adoption;

(d) An Eligible Employee or Eligible Dependent's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

(e) An enrollee adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(f) An Eligible Employee or Eligible Dependent gains access to new qualified health plans as a result of a permanent move;

(g) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and

(h) An Eligible Employee or Eligible Dependent demonstrates that the individual meets other exceptional circumstances.

EFFECTIVE DATE

Your insurance will become in effect as follows:

(1) If enrollment is received between the first (1st) and the fifteenth (15th) day of the enrollment period, coverage will be effective on the first day of the following month; and

(2) If enrollment is received between the sixteenth (16th) and the last day of the enrollment period, coverage will be effective on the first day of the second following month.

TERMINATION DATE

Coverage may be terminated, as follows:

(1) You may terminate coverage with appropriate notice.

(2) We may terminate coverage in the following circumstances:
(a) You are no longer eligible for coverage through the Exchange;
(b) Non-payment of premiums;
(c) Your coverage is rescinded;
(d) We terminate or decertify; or
(e) You change insurance carriers during an annual open enrollment period or special enrollment period.

PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:
(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty one (31) days of that date; or
(2) the first day of the next calendar month following the date You complete one calendar month of active full time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or
(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the

Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;

(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;

(3) the date Insured ceases to be in a class eligible for insurance under this plan;

(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;

(5) the day before the due date of any premium that remains unpaid at the end of the grace period;

(6) the date the Group Policy terminates;

(7) the date the Subscriber's Employer ceases to be a Participating Employer;

(8) the date the number of the Participating Employer's Subscribers falls below 2;

(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or

(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:

(1) the date Your insurance terminates;

(2) the date You fail to make a contribution for dependent insurance;

(3) the date You cease to be in a class eligible for dependent insurance; or

(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. ~~During the Grace Period, this Group Policy will remain in force.~~ If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the last date paid in full ~~Grace Period~~.

Termination of Group Policy: [This Group Policy will terminate if: (1) the Group Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status.] We may terminate this Group Policy[at any time following the first renewal date]by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;

- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or
(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.

(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:

(A) the due date to pay any required premium (if premium is not paid by that date).

(B) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.

(C) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)

~~I.~~ a date which is:

(D)

~~II.~~ 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.

I.

~~III.~~II. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact [BEST Life's Customer Service at ~~[~~1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to [BEST Life and Health Insurance Company, Attn: Appeals, ~~[~~P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 10 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

[ENDORSEMENT - SUPPLEMENTAL FAMILY DENTAL INSURANCE

If the Policyholder selected Family Dental Coverage, then this Endorsement modifies, supplements, and becomes a part of the Certificate for Covered Employees and their Covered Dependents over the age of 18 years. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

Formatt

Dental Plan Schedule of Benefits
For Eligible Persons over 19 years

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible [(Applies to Basic and Major) – 3 Deductible Maximum per Family]	[$0-100]	
Preventive Care Services [Routine oral exam, cleanings, X-rays]	100%	[100-70]%
Basic Services [Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology]	[90-50]%	[80-20]%
Major Services [Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery]	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
[Endodontic Services	[Basic][Major]]	
[Periodontic Services	[Basic][Major]]	

COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Formatt

CLASS A – Basic Services:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;

Formatt

(2) Bitewing x-rays not more often than once every twelve (12) months per individual;

(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;

(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS B – Intermediate Services:

(1) Pathology;

Formatt

(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);

(3) Emergency palliative treatment;

(4) Limited oral exam not more than once every six months;

(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a

Covered Dental Expense on this Plan;

(6) Surgical extraction, including impaction:
  (a) erupted tooth;
  (b) soft tissue impaction;
  (c) partial bony impaction;
  (d) complete bony impaction;

(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);

(8) Periodontics (tissues and gums);

(9) Periodontal exam (not in addition to a routine oral exam);

(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;

(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);

(12) Endodontics (pulp capping and root canal); and

(13) Oral surgery:
  (a) root recovery (surgical removal of residual root);
  (b) oral antral fistula closure;
  (c) removal of a dentigerous or odontogenic cyst;
  (d) incision and drainage of an abscess;
  (e) removal of lateral exostosis;
  (f) frenulectomy.

CLASS C - Major Services: [Employer groups without continuous, prior coverage for the twelve (12) month period prior to enrolling with Us will have a twelve (12) month Waiting Period before this Policy covers Major dental services.] Major Dental Services are as follows:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);

(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;

(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;

(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  (a) accidental injury requiring oral surgical treatment, or
  (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.

(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non- chewing injury while covered;

(6) Repair or reline of dentures and bridgework[;

(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;

(b) implant supported prosthetics;
(c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
(d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
(e) implant maintenance.]

[ENDORSEMENT – ORTHODONTIC SERVICES

If the Policyholder selected Orthodontic Coverage, then this Endorsement modifies, supplements, and becomes a part of the Certificate for Covered Employees and their Covered Dependents up to the age of 19 years. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

Optional Child Orthodontic Benefit

This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

Schedule of Orthodontic Benefits

Benefit Description	In Network	Out-of-Network
Orthodontic Coinsurance	50%	50%
Calendar Year Maximum	$500	$500
Lifetime Maximum	$1000	$1000

The initial services may be no greater than [1/3][1/2] of the Lifetime Maximum Benefit Amount; thereafter, follow-up visits will be paid equally on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;

Termination of Coverage

Benefits end once braces are removed or when coverage is cancelled, whichever is first.

[Waiting Period

A 12-Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the 12-Month Waiting Period immediately following the effective date of this Plan.]

[Deductible

The Plan's deductible does not apply to this benefit.]]

Exclusion

(1) Medically necessary orthodontic services.

(2) Orthodontic Services for Insureds who are over 18 years of age.

Underwritten by BEST Life and Health Insurance Company]

Formatt

Formatt

Formatt

Formatt

Formatt

Formatt

Formatt
Space Be

~~Underwritten by BEST Life and Health Insurance Company~~

Formatt
3.8 pt

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Policy provides dental coverage only.

GFD-PPO-POL-0113TN

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: ABC Company

Group Policy Effective Date: [XX-XX-XXXX]

Group Policy Number: [XXX]

State of Delivery: Tennessee

Premiums Due On: 1st of each month

First Renewal Date: [XX-XX-XXXX]

[Intentionally Blank Page]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

	[BEST Life Child Dental] [Plus] Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	$[0][50]	$[50][100]
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
Basic Services Coinsurance – Fillings	[70][55]%	[60][40]%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

[Dental Plan Schedule of Benefits
For Adults and Dependent Children between 19 and 26]

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	[$0-100]	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	[100-70]%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
Major Services Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
Endodontic Services	[Basic][Major]	
Periodontic Services	[Basic][Major]	
[Dental Accident Benefit	$1,000]	
Usual and Customary Reimbursement	Fee Schedule	[70th - 95th] Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;

f. tooth reimplantation;
g. surgical access of unerupted tooth;
h. alveoloplasty;
i. removal of exostosis;
j. incision and drainage of abscess;
k. suture of recent small wounds up to five (5) cm
l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

Class IV – Medically Necessary Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

[Optional Child Orthodontic Benefit
This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

(1) All procedures connected to orthodontic treatment at 50% coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child;
(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;
(3) Periodic follow-up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;
(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.
(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of

Benefits.

[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]

The Plan's deductible does not apply to this benefit.]

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;

(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants

per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
  (a) root recovery (surgical removal of residual root);
  (b) oral antral fistula closure;
  (c) removal of a dentigerous or odontogenic cyst;
  (d) incision and drainage of an abscess;
  (e) removal of lateral exostosis;
  (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  (a) accidental injury requiring oral surgical treatment, or
  (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  (b) implant supported prosthetics;
  (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  (e) implant maintenance].

[**Supplemental Dental Accident Benefit**

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.]

EXCLUSIONS ON
SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics[are not covered for patients under the age of sixteen (16)];
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;
(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction

of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.]

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;
(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, 2 or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:

(1) Your lawful spouse or domestic partner and
(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a

dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
   (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
   (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or

(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group

practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:

(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or

(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or

(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:
(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
    (a) approved leave of absence, 3 months;
    (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
    (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or

(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other

Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: [This Group Policy will terminate if: (1) the Group Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status.] We may terminate this Group Policy[at any time following the first renewal date]by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide

and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 10 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit

in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Policy provides dental coverage only.

GFD-PPO-POL-0113TN

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: ABC Company

Group Policy Effective Date: [XX-XX-XXXX]

Group Policy Number: [XXX]

State of Delivery: Tennessee

Premiums Due On: 1st of each month

First Renewal Date: [XX-XX-XXXX]

[Intentionally Blank Page]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

	[BEST Life Child Dental] [Plus] Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	$[0][50]	$[50][100]
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
Basic Services Coinsurance – Fillings	[70][55]%	[60][40]%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

[Dental Plan Schedule of Benefits
For Adults and Dependent Children between 19 and 26]

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	[$0-100]	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	[100-70]%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
Major Services Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
Endodontic Services	[Basic][Major]	
Periodontic Services	[Basic][Major]	
[Dental Accident Benefit	$1,000]	
Usual and Customary Reimbursement	Fee Schedule	[70th - 95th] Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;

f. tooth reimplantation;
g. surgical access of unerupted tooth;
h. alveoloplasty;
i. removal of exostosis;
j. incision and drainage of abscess;
k. suture of recent small wounds up to five (5) cm
l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

Class IV – Medically Necessary Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

[Optional Child Orthodontic Benefit
This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

(1) All procedures connected to orthodontic treatment at 50% coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child;
(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;
(3) Periodic follow-up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;
(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.
(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of

Benefits.

[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]

The Plan's deductible does not apply to this benefit.]

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;

(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants

per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
  (a) root recovery (surgical removal of residual root);
  (b) oral antral fistula closure;
  (c) removal of a dentigerous or odontogenic cyst;
  (d) incision and drainage of an abscess;
  (e) removal of lateral exostosis;
  (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  (a) accidental injury requiring oral surgical treatment, or
  (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  (b) implant supported prosthetics;
  (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  (e) implant maintenance].

[**Supplemental Dental Accident Benefit**

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.]

EXCLUSIONS ON
SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics[are not covered for patients under the age of sixteen (16)];
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;
(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction

of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.]

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;
(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, 2 or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:

(1) Your lawful spouse or domestic partner and
(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a

dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
   (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
   (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or

(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group

practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:

(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or

(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or

(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:
(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
    (a) approved leave of absence, 3 months;
    (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
    (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or

(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other

Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: [This Group Policy will terminate if: (1) the Group Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status.] We may terminate this Group Policy[at any time following the first renewal date]by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide

and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 10 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit

in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Certificate provides dental coverage only.

GFD-PPO-CERT-0113TN

CERTIFICATE OF GROUP INSURANCE

Issued By

BEST Life and Health Insurance Company

A STOCK COMPANY
(Herein called the "We," "Us," "Company" or "BEST Life")

BEST Life and Health Insurance Company certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Group Policy. The Group Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Group Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

PLAN EFFECTIVE DATE: Insurance is in effect on the date shown on the Certificate Statement of Coverage.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].

[ ]

President

[ ]

Secretary

GROUP PPO DENTAL
NON-PARTICIPATING

THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.

[Intentionally Blank Page]

This Certificate Is Not Valid
Unless There Is a Complete Statement of Coverage

Statement of Coverage

DENTAL

INSURANCE SUBSCRIBER NAME: [JOHN D. DOE]
CERTIFICATE EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):
[JANE DOE 01/01/2014]
[JON DOE 01/01/2014]

PARTICIPATING EMPLOYER NAME: [CUSTOMER NAME]
PARTICIPATING EMPLOYER NUMBER: [TN00XXX0000XX]

[PLAN: [PPO HIGH]
DEDUCTIBLE: [$50]
ANNUAL MAXIMUM: [$1,000]]

GROUP POLICY No.: [XXXXXXXXX]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

	[BEST Life Child Dental] [Plus] Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	$[0][50]	$[50][100]
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
Basic Services Coinsurance – Fillings	[70][55]%	[60][40]%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

[Dental Plan Schedule of Benefits
For Adults and Dependent Children between 19 and 26]

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	[$0-100]	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	[100-70]%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
Major Services Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
Endodontic Services	[Basic][Major]	
Periodontic Services	[Basic][Major]	
[Dental Accident Benefit	$1,000]	
Usual and Customary Reimbursement	Fee Schedule	[70th - 95th] Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;

f. tooth reimplantation;
g. surgical access of unerupted tooth;
h. alveoloplasty;
i. removal of exostosis;
j. incision and drainage of abscess;
k. suture of recent small wounds up to five (5) cm
l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

Class IV – Medically Necessary Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

[Optional Child Orthodontic Benefit
This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

(1) All procedures connected to orthodontic treatment at 50% coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child;
(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;
(3) Periodic follow-up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;
(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.
(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of

Benefits.

[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]

The Plan's deductible does not apply to this benefit.]

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;

(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants

per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
  (a) root recovery (surgical removal of residual root);
  (b) oral antral fistula closure;
  (c) removal of a dentigerous or odontogenic cyst;
  (d) incision and drainage of an abscess;
  (e) removal of lateral exostosis;
  (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  (a) accidental injury requiring oral surgical treatment, or
  (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  (b) implant supported prosthetics;
  (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  (e) implant maintenance].

[**Supplemental Dental Accident Benefit**

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.]

EXCLUSIONS ON
SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics[are not covered for patients under the age of sixteen (16)];
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;
(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction

of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.]
]

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;
(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, 2 or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:

(1) Your lawful spouse or domestic partner and
(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable

to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
   (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
   (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or

(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:

(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or

(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or

(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:
(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
    (a) approved leave of absence, 3 months;
    (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
    (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;

(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: [This Group Policy will terminate if: (1) the Group Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status.] We may terminate this Group Policy[at any time following the first renewal date] by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after

the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and

Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on “Forms”].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life’s Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 10 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Certificate provides dental coverage only.

GFD-PPO-CERT-0113TN

CERTIFICATE OF GROUP INSURANCE

Issued By

BEST Life and Health Insurance Company

A STOCK COMPANY
(Herein called the "We," "Us," "Company" or "BEST Life")

BEST Life and Health Insurance Company certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Group Policy. The Group Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Group Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

PLAN EFFECTIVE DATE: Insurance is in effect on the date shown on the Certificate Statement of Coverage.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].

[ ]

President

[ ]

Secretary

GROUP PPO DENTAL
NON-PARTICIPATING

THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.

[Intentionally Blank Page]

This Certificate Is Not Valid
Unless There Is a Complete Statement of Coverage

Statement of Coverage

DENTAL

INSURANCE SUBSCRIBER NAME: [JOHN D. DOE]
CERTIFICATE EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):
[JANE DOE 01/01/2014]
[JON DOE 01/01/2014]

PARTICIPATING EMPLOYER NAME: [CUSTOMER NAME]
PARTICIPATING EMPLOYER NUMBER: [TN00XXX0000XX]

[PLAN: [PPO HIGH]
DEDUCTIBLE: [$50]
ANNUAL MAXIMUM: [$1,000]]

GROUP POLICY No.: [XXXXXXXXX]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

	[BEST Life Child Dental] [Plus] Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	$[0][50]	$[50][100]
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
Basic Services Coinsurance – Fillings	[70][55]%	[60][40]%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

[Dental Plan Schedule of Benefits
For Adults and Dependent Children between 19 and 26]

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	[$0-100]	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	[100-70]%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
Major Services Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
Endodontic Services	[Basic][Major]	
Periodontic Services	[Basic][Major]	
[Dental Accident Benefit	$1,000]	
Usual and Customary Reimbursement	Fee Schedule	[70th - 95th] Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;

f. tooth reimplantation;
g. surgical access of unerupted tooth;
h. alveoloplasty;
i. removal of exostosis;
j. incision and drainage of abscess;
k. suture of recent small wounds up to five (5) cm
l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

Class IV – Medically Necessary Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

[Optional Child Orthodontic Benefit
This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

(1) All procedures connected to orthodontic treatment at 50% coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child;
(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;
(3) Periodic follow-up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;
(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.
(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of

Benefits.

[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]

The Plan's deductible does not apply to this benefit.]

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;

(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants

per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
  (a) root recovery (surgical removal of residual root);
  (b) oral antral fistula closure;
  (c) removal of a dentigerous or odontogenic cyst;
  (d) incision and drainage of an abscess;
  (e) removal of lateral exostosis;
  (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  (a) accidental injury requiring oral surgical treatment, or
  (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  (b) implant supported prosthetics;
  (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  (e) implant maintenance].

[**Supplemental Dental Accident Benefit**

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.]

EXCLUSIONS ON
SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics[are not covered for patients under the age of sixteen (16)];
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;
(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction

of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.]
]

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;
(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, 2 or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:

(1) Your lawful spouse or domestic partner and
(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable

to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
   (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
   (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or

(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:

(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or

(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or

(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:
(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
    (a) approved leave of absence, 3 months;
    (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
    (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;

(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: [This Group Policy will terminate if: (1) the Group Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact; (2) the Group Policyholder is no longer in a class eligible for coverage, (3) the Group Policyholder requests coverage to cease; (4) BEST Life ceases to offer coverage as provided under this Policy, or (5) BEST Life loses Certification status.] We may terminate this Group Policy[at any time following the first renewal date] by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after

the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and

Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on “Forms”].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life’s Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 10 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Policy provides dental coverage only.

GFD-PPO-POL-0113TN

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: ABC Company

Group Policy Effective Date: [XX-XX-XXXX]

Group Policy Number: [XXX]

State of Delivery: Tennessee

Premiums Due On: 1st of each month

First Renewal Date: [XX-XX-XXXX]

[Intentionally Blank Page]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

	[BEST Life Child Dental] [Plus] Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	$[0][50]	$[50][100]
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
Basic Services Coinsurance – Fillings	[70][55]%	[60][40]%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

[Dental Plan Schedule of Benefits
For Adults and Dependent Children between 19 and 26]

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	[$0-100]	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	[100-70]%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
Major Services Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
Endodontic Services	[Basic][Major]	
Periodontic Services	[Basic][Major]	
[Dental Accident Benefit	$1,000]	
Usual and Customary Reimbursement	Fee Schedule	[70th - 95th] Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;

f. tooth reimplantation;
g. surgical access of unerupted tooth;
h. alveoloplasty;
i. removal of exostosis;
j. incision and drainage of abscess;
k. suture of recent small wounds up to five (5) cm
l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

Class IV – Medically Necessary Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

[Optional Child Orthodontic Benefit
This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

(1) All procedures connected to orthodontic treatment at 50% coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child;
(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;
(3) Periodic follow-up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;
(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.
(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of

Benefits.

[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]

The Plan's deductible does not apply to this benefit.]

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;

(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants

per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
  (a) root recovery (surgical removal of residual root);
  (b) oral antral fistula closure;
  (c) removal of a dentigerous or odontogenic cyst;
  (d) incision and drainage of an abscess;
  (e) removal of lateral exostosis;
  (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  (a) accidental injury requiring oral surgical treatment, or
  (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  (b) implant supported prosthetics;
  (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  (e) implant maintenance].

[**Supplemental Dental Accident Benefit**

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.]

EXCLUSIONS ON
SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics[are not covered for patients under the age of sixteen (16)];
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;
(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction

of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.]

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;
(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, 2 or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:

(1) Your lawful spouse or domestic partner and
(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a

dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
   (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
   (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or

(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group

practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:

(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or

(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or

(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:
(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
    (a) approved leave of absence, 3 months;
    (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
    (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or

(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other

Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly

in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and

extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
   (1) the due date to pay any required premium (if premium is not paid by that date).
   (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
   (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
   (4) a date which is:
      1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
      2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written

request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 10 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal

court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

Group Insurance Policy

Dental PPO Plan

BEST Life™
BEST Life and Health Insurance Company

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Policy provides dental coverage only.

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of TennesseeUtah. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: ~~Beneficial Employees Security Trust of Utah~~ABC Company

Group Policy Effective Date: [XX-XX-XXXX] **Group Policy Number:** [XXX]

State of Delivery: Tennessee~~Utah~~

Premiums Due On: 1st of each month **First Renewal Date:** [XX-XX-XXXX]

[Intentionally Blank Page]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [The Trustee of the Beneficial Employees Security Trust of Utah.]ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

	[PPO Dental High] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[1,000 – 1,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	100%
Basic Services Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	90%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	60%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Basic	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Mid] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,500	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	50%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]
[

	[PPO Dental Basic] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	50%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]
[

	[PPO Dental Value] Plan	
Benefits Description	In-Network [Network]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	50%	20%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

	[BEST Life Child Dental] [Plus] Plan	
Procedure Categories	In-Network [Network Name]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	$[0][50]	$[50][100]
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
Basic Services Coinsurance – Fillings	[70][55]%	[60][40]%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%

Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

[Dental Plan Schedule of Benefits
For Adults and Dependent Children between 19 and 26]

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	[$0-100]	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	[100-70]%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
Major Services Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
Endodontic Services	[Basic][Major]	
Periodontic Services	[Basic][Major]	
[Dental Accident Benefit	$1,000]	
Usual and Customary Reimbursement	Fee Schedule	[70th - 95th] Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

~~**PART 2 - BENEFITS**~~

~~**Covered Services**~~
~~Covered Services are those services described below, unless they are limited or excluded elsewhere~~

in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every 12 months per individual;
(2) Bitewing x-rays not more often than once every 12 months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five years; any combination of eight or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
    (a) root recovery (surgical removal of residual root);
    (b) oral antral fistula closure;
    (c) removal of a dentigerous or odontogenic cyst;
    (d) incision and drainage of an abscess;
    (e) removal of lateral exostosis;
    (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required

because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;

(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
   (a) accidental injury requiring oral surgical treatment, or
   (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.

(5) Replacement of a full denture or bridgework if the replacement is made more than seven years after the date of installation, unless:
   (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
   (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;

(6) Repair or reline of dentures and bridgework;

(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant related procedures, not to exceed the cost of the fixed prosthetic:
   (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
   (b) implant supported prosthetics;
   (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
   (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
   (e) implant maintenance.

[**Note:** Unless the twelve (12) month waiting period requirement for Orthodontic Procedures has been met, the services below are not covered benefits for any treatment that begin during the twelve (12) month period immediately following Your effective date of coverage.]

[**CLASS IV – Orthodontic Procedures Include:**
Provides orthodontic treatment for Dependent children until the end of the month of their 18th birthday, to be payable as follows:

(1) All procedures performed in connection with orthodontic treatment subject to the coinsurance level, Calendar Year and Lifetime Maximum Benefit as defined in the Schedule of Benefits;
(2) Benefits for the initial placement up to [1/3][1/2] of the Lifetime Maximum Benefit Amount, as an initial down payment;
(3) Periodic follow up visits will be payable on a monthly basis during the scheduled course of orthodontic treatment, up to the Lifetime Maximum Amount;
(4) Orthodontic benefits end once braces are removed or at the cancellation of coverage, whichever comes first.]

Supplemental Dental Accident Benefit

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;

f. tooth reimplantation;
g. surgical access of unerupted tooth;
h. alveoloplasty;
i. removal of exostosis;
j. incision and drainage of abscess;
k. suture of recent small wounds up to five (5) cm
l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

Class IV – Medically Necessary Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

[Optional Child Orthodontic Benefit
This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

(1) All procedures connected to orthodontic treatment at 50% coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child;
(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;
(3) Periodic follow-up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;
(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.
(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of

Benefits.

[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]

The Plan's deductible does not apply to this benefit.]

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;

(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants

per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
(a) root recovery (surgical removal of residual root);
(b) oral antral fistula closure;
(c) removal of a dentigerous or odontogenic cyst;
(d) incision and drainage of an abscess;
(e) removal of lateral exostosis;
(f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
(a) accidental injury requiring oral surgical treatment, or
(b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
(a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
(b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
(a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
(b) implant supported prosthetics;
(c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
(d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
(e) implant maintenance].

[Supplemental Dental Accident Benefit

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.]

EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics[are not covered for patients under the age of sixteen (16)];
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;
(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction

of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.]

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);

(2) Emergency treatment; or

(3) Oral examination and prophylaxis.

~~Predetermination is required for the following dental services:~~

~~(1) Crowns, Anterior, except with posts or root canal;~~

~~(2) Crowns, two (2) or more Posterior, except with posts or root canal;~~

~~(3) Inlays or Onlays, two (2) or more, except with posts or root canal;~~

~~(4) Laminates;~~

~~(5) Anterior composites;~~

~~(6) Two (2) or more multiple surfaces;~~

~~(7) Bridges – initial or replacement;~~

~~(8) Eligible partial dentures – initial or replacement;~~

~~(9) Periodontal surgery over $500;~~

~~(10) Full bony impactions, two (2) or more.~~

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;

(2) Panoramic film for children under age six (6);

(3) Periodontal scaling and root planing;

(4) Occlusal orthotic devices;

(5) Appliance therapy;

(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;

(2) Crowns, 2 or more Posterior, except with posts or root canal;

(3) Inlays or Onlays, 2 or more, except with posts or root canal;

(4) Laminates;

(5) Anterior composites;

(6) 2 or more multiple surfaces;

(7) Bridges – initial or replacement;

(8) Eligible partial dentures – initial or replacement;

(9) Periodontal surgery over $500;

(10) Full bony impactions, 2 or more.

We will have ~~thirty~~ (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

~~PART 4 – EXCLUSIONS~~

~~The following exclusions are not Covered Services. No payments will be made by Us for these services:~~

~~(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;~~

~~(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;~~

~~(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;~~

~~(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;~~

~~(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;~~

~~(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;~~

~~(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;~~

~~(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;~~

~~(9) Implants, implant services and implant supported prosthetics are not covered for patients under the age of 16;~~

~~(10) Expenses incurred for veneers and related procedures;~~
~~(11) Replacement of a lost or stolen or discarded prosthetic device;~~
~~(12) Adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;~~
~~(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;~~
~~(14) If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;~~
~~(15) X rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;~~
~~(16) The extraction of immature erupting third molars and non pathologic, asymptomatic third molar extractions;~~
~~(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;~~
~~(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;~~
~~(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;~~
~~(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;~~
~~(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);~~
~~(22) Expenses incurred for congenital or developmental malformations;~~
~~(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);~~
~~(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;~~
~~(25) Chemotherapeutic agents and any other experimental procedures;~~
~~(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;~~
~~(27) Expenses that are applied toward satisfaction of a Deductible, if any;~~
~~(28) Services and supplies performed outside of the United States of America;~~
~~(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step parent, grandparent, brother, sister, cousin or in-law;~~
~~(30) Expenses for services for which You would not legally have to pay if there were no insurance;~~
~~(31) Services not completed on or before the date of termination;~~
~~(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;~~
~~(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;~~
~~(34) Expenses incurred for services covered on a pediatric only dental plan.~~

PART 45 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:

(1) Your lawful spouse or domestic partner and

(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or

(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
   (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
   (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or

(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or

a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 56 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:

(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or

(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or

(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:

(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or

(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;

(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;

(3) the date Insured ceases to be in a class eligible for insurance under this plan;

(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;

(5) the day before the due date of any premium that remains unpaid at the end of the grace period;

(6) the date the Group Policy terminates;

(7) the date the Subscriber's Employer ceases to be a Participating Employer;

(8) the date the number of the Participating Employer's Subscribers falls below 2;

(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or

(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:

(1) the date Your insurance terminates;

(2) the date You fail to make a contribution for dependent insurance;

(3) the date You cease to be in a class eligible for dependent insurance; or

(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART ~~7~~6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7~~8~~ –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8~~9~~ – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:

- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or
(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the

termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation

rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.

(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:

(1) the due date to pay any required premium (if premium is not paid by that date).

(2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.

(3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)

(4) a date which is:

1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9~~10~~ – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

~~**PART 11 - SUMMARY PLAN DESCRIPTION SUPPLEMENT**~~

~~The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of your Certificate, it forms the Summary Plan Description.~~

~~(1) NAME OF PLAN: [Beneficial Employees Security Trust], [P.O. Box 3100, Newport Beach, California 92658-9027].~~

~~(2) PLAN IDENTIFICATION NUMBER: [501].~~

~~(3) TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN: The plan is administered by [BEST Life and Health Insurance Company] located at [2505 McCabe Way, Irvine, California 92614], [(800) 433-0088]. Benefits are insured in accordance with the Group Dental Insurance Policy issued by BEST Life.~~

~~(4) AGENT FOR SERVICE: The Chief Legal counsel of BEST Life at [the above address].~~

~~(5) TRUSTEE OF THE PLAN: [Wells Fargo Bank, N.A., 180 South Main Street, 2nd Floor, Salt Lake City, Utah 84101].~~

~~(6) SOURCE OF PLAN CONTRIBUTION: The contributions necessary to finance the plan are made by the employer and employees.~~

~~(7) DATE OF END OF THE PLAN'S FISCAL YEAR: [December 31].~~

PART 1~~0~~2 ~~-~~ - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit

in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Certificate provides dental coverage only.

GFD-PPO-CERT-0113TN

CERTIFICATE OF GROUP INSURANCE

Issued By

BEST Life and Health Insurance Company

A STOCK COMPANY
(Herein called the "We," "Us," "Company" or "BEST Life")

BEST Life and Health Insurance Company certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Group Policy. The Group Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Group Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

PLAN EFFECTIVE DATE: Insurance is in effect on the date shown on the Certificate Statement of Coverage.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].

[ ]

President

[ ]

Secretary

GROUP PPO DENTAL
NON-PARTICIPATING

THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.

[Intentionally Blank Page]

This Certificate Is Not Valid
Unless There Is a Complete Statement of Coverage

Statement of Coverage

DENTAL

INSURANCE SUBSCRIBER NAME: [JOHN D. DOE]
CERTIFICATE EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):
[JANE DOE 01/01/2014]
[JON DOE 01/01/2014]

PARTICIPATING EMPLOYER NAME: [CUSTOMER NAME]
PARTICIPATING EMPLOYER NUMBER: [TN00XXX0000XX]

[PLAN: [PPO HIGH]
DEDUCTIBLE: [$50]
ANNUAL MAXIMUM: [$1,000]]

GROUP POLICY No.: [XXXXXXXXX]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

	[BEST Life Child Dental] [Plus] Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	$[0][50]	$[50][100]
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
Basic Services Coinsurance – Fillings	[70][55]%	[60][40]%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

[Dental Plan Schedule of Benefits
For Adults and Dependent Children between 19 and 26]

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	[$0-100]	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	[100-70]%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
Major Services Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
Endodontic Services	[Basic][Major]	
Periodontic Services	[Basic][Major]	
[Dental Accident Benefit	$1,000]	
Usual and Customary Reimbursement	Fee Schedule	[70th - 95th] Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;

f. tooth reimplantation;
g. surgical access of unerupted tooth;
h. alveoloplasty;
i. removal of exostosis;
j. incision and drainage of abscess;
k. suture of recent small wounds up to five (5) cm
l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

Class IV – Medically Necessary Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

[Optional Child Orthodontic Benefit
This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

(1) All procedures connected to orthodontic treatment at 50% coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child;
(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;
(3) Periodic follow-up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;
(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.
(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of

Benefits.

[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]

The Plan's deductible does not apply to this benefit.]

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;

(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants

per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
  (a) root recovery (surgical removal of residual root);
  (b) oral antral fistula closure;
  (c) removal of a dentigerous or odontogenic cyst;
  (d) incision and drainage of an abscess;
  (e) removal of lateral exostosis;
  (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  (a) accidental injury requiring oral surgical treatment, or
  (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  (b) implant supported prosthetics;
  (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  (e) implant maintenance].

[**Supplemental Dental Accident Benefit**

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.]

EXCLUSIONS ON
SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics[are not covered for patients under the age of sixteen (16)];
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;
(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction

of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.]
]

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;
(2) Panoramic film for children under age six (6);
(3) Periodontal scaling and root planing;
(4) Occlusal orthotic devices;
(5) Appliance therapy;
(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, 2 or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, 2 or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) 2 or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

PART 4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:

(1) Your lawful spouse or domestic partner and
(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable

to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
   (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
   (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or

(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:

(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or

(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or

(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:
(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
    (a) approved leave of absence, 3 months;
    (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
    (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;

(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 6 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 10 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide

the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Certificate provides dental coverage only.

CERTIFICATE OF GROUP INSURANCE

Issued By

BEST Life and Health Insurance Company

A STOCK COMPANY
(Herein called the "We," "Us," "Company" or "BEST Life")

BEST Life and Health Insurance Company certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Group Policy. The Group Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Group Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

PLAN EFFECTIVE DATE: Insurance is in effect on the date shown on the Certificate Statement of Coverage.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Tennessee~~Utah~~. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].

[ ]

President

[ ]

Secretary

GROUP PPO DENTAL
NON-PARTICIPATING

THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.

[Intentionally Blank Page]

This Certificate Is Not Valid
Unless There Is a Complete Statement of Coverage

Statement of Coverage

DENTAL

INSURANCE SUBSCRIBER NAME: [JOHN D. DOE]
CERTIFICATE EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):
[JANE DOE 01/01/2014]
[JON DOE 01/01/2014]

PARTICIPATING EMPLOYER NAME: [CUSTOMER NAME]
PARTICIPATING EMPLOYER NUMBER: [TN00XXX0000XX]

[**PLAN:** [PPO HIGH]
DEDUCTIBLE: [$50]
ANNUAL MAXIMUM: [$1,000]]

GROUP POLICY No.: [XXXXXXXXX]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [The Trustee of the Beneficial Employees Security Trust of Utah.]ABC Company].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

	[PPO Dental High] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[1,000 – 1,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	100%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	90%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	60%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Basic	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Mid] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,500	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	50%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Basic] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	50%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]
[

	[PPO Dental Value] Plan	
Benefits Description	In-Network [Network]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	50%	20%
Major Services Crowns & gold fillings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

Pediatric Dental Plan Schedule of Benefits
For Children to Age 19

	[BEST Life Child Dental] [Plus] Plan	
Procedure Categories	In-Network [Network Name]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	$[0][50]	$[50][100]
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
Basic Services Coinsurance – Fillings	[70][55]%	[60][40]%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%

Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

[Dental Plan Schedule of Benefits
For Adults and Dependent Children between 19 and 26]

	[BEST Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[750 – 2,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	[$0-100]	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	[100-70]%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
Major Services Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures, oral surgery	[60-0]%	[50-0]%
[Major Services Waiting Period	12 Months]	
Endodontic Services	[Basic][Major]	
Periodontic Services	[Basic][Major]	
[Dental Accident Benefit	$1,000]	
Usual and Customary Reimbursement	Fee Schedule	[70th - 95th] Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

~~**PART 2 - BENEFITS**~~

~~**Covered Services**~~
~~Covered Services are those services described below, unless they are limited or excluded elsewhere~~

in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every 12 months per individual;
(2) Bitewing x-rays not more often than once every 12 months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five years; any combination of eight or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
    (a) root recovery (surgical removal of residual root);
    (b) oral antral fistula closure;
    (c) removal of a dentigerous or odontogenic cyst;
    (d) incision and drainage of an abscess;
    (e) removal of lateral exostosis;
    (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required

because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;

(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
   (a) accidental injury requiring oral surgical treatment, or
   (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.

(5) Replacement of a full denture or bridgework if the replacement is made more than seven years after the date of installation, unless:
   (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
   (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;

(6) Repair or reline of dentures and bridgework;

(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant related procedures, not to exceed the cost of the fixed prosthetic:
   (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
   (b) implant supported prosthetics;
   (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
   (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
   (e) implant maintenance.

[**Note:** Unless the twelve (12) month waiting period requirement for Orthodontic Procedures has been met, the services below are not covered benefits for any treatment that begin during the twelve (12) month period immediately following Your effective date of coverage.]

[**CLASS IV – Orthodontic Procedures Include:**
Provides orthodontic treatment for Dependent children until the end of the month of their 18th birthday, to be payable as follows:

(1) All procedures performed in connection with orthodontic treatment subject to the coinsurance level, Calendar Year and Lifetime Maximum Benefit as defined in the Schedule of Benefits;
(2) Benefits for the initial placement up to [1/3][1/2] of the Lifetime Maximum Benefit Amount, as an initial down payment;
(3) Periodic follow up visits will be payable on a monthly basis during the scheduled course of orthodontic treatment, up to the Lifetime Maximum Amount;
(4) Orthodontic benefits end once braces are removed or at the cancellation of coverage, whichever comes first.]

Supplemental Dental Accident Benefit

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.

PART 2 - BENEFITS AND EXCLUSIONS

COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every six (6) months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
(3) Topical fluoride varnish not more often than twice every twelve (12) months;
(4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
(5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every six (6) months;
(7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
(8) Comprehensive oral evaluation not more often than once every six (6) months;
(9) Comprehensive periodontal evaluation not more often than once every six (6) months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every six (6) months;
(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
(6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
(7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;

f. tooth reimplantation;
g. surgical access of unerupted tooth;
h. alveoloplasty;
i. removal of exostosis;
j. incision and drainage of abscess;
k. suture of recent small wounds up to five (5) cm
l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
(3) Endodontics (root canal)
(4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
(5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
(6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
(7) Full mouth debridement limited to one (1) per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
(9) Implants and implant services once every sixty (60) months only if medically necessary;
(10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

Class IV – Medically Necessary Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

[Optional Child Orthodontic Benefit
This benefit covers non-medically necessary orthodontic treatment for Your Dependent Children until the end of the month of their 18th birthday. Child orthodontia benefit includes:

(1) All procedures connected to orthodontic treatment at 50% coverage, up to $500 Calendar Year Maximum, $1,000 Lifetime Maximum, per child;
(2) Benefits for the initial down payment up to [1/3][1/2] of the Lifetime Maximum Benefit Amount;
(3) Periodic follow-up visits will be paid on a monthly basis over the remaining treatment period, up to the Lifetime Maximum Benefit;
(4) Benefits end once braces are removed or when coverage is cancelled, whichever is first.
(5) Subject to the coinsurance, Calendar Year and Lifetime Maximum as shown on the Schedule of

Benefits.

[A [12][24] Month Waiting Period immediately following the effective date applies to this Plan. Orthodontia is not covered during the [12][24] Month Waiting Period immediately following the effective date of this Plan.]

The Plan's deductible does not apply to this benefit.]

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a five (5) year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
(12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;

(19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(20) Services not completed on or before the date of termination;
(21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(22) Expenses that are applied toward satisfaction of a Deductible, if any;
(23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Expenses incurred for veneers and related procedures;
(27) Services and supplies performed outside of the United States of America.

[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
(2) Bitewing x-rays not more often than once every twelve (12) months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six (6) months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants

per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
(a) root recovery (surgical removal of residual root);
(b) oral antral fistula closure;
(c) removal of a dentigerous or odontogenic cyst;
(d) incision and drainage of an abscess;
(e) removal of lateral exostosis;
(f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
(a) accidental injury requiring oral surgical treatment, or
(b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
(a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
(b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework[;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
(a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
(b) implant supported prosthetics;
(c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
(d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
(e) implant maintenance].

[Supplemental Dental Accident Benefit

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.]

EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics[are not covered for patients under the age of sixteen (16)];
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;
(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction

of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.]
]

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);

(2) Emergency treatment; or

(3) Oral examination and prophylaxis.

~~Predetermination is required for the following dental services:~~

~~(1) Crowns, Anterior, except with posts or root canal;~~

~~(2) Crowns, two (2) or more Posterior, except with posts or root canal;~~

~~(3) Inlays or Onlays, two (2) or more, except with posts or root canal;~~

~~(4) Laminates;~~

~~(5) Anterior composites;~~

~~(6) Two (2) or more multiple surfaces;~~

~~(7) Bridges – initial or replacement;~~

~~(8) Eligible partial dentures – initial or replacement;~~

~~(9) Periodontal surgery over $500;~~

~~(10) Full bony impactions, two (2) or more.~~

Predetermination is required for the following dental services for children:

(1) Medically necessary services or supplies;

(2) Panoramic film for children under age six (6);

(3) Periodontal scaling and root planing;

(4) Occlusal orthotic devices;

(5) Appliance therapy;

(6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

(1) Crowns, Anterior, except with posts or root canal;

(2) Crowns, 2 or more Posterior, except with posts or root canal;

(3) Inlays or Onlays, 2 or more, except with posts or root canal;

(4) Laminates;

(5) Anterior composites;

(6) 2 or more multiple surfaces;

(7) Bridges – initial or replacement;

(8) Eligible partial dentures – initial or replacement;

(9) Periodontal surgery over $500;

(10) Full bony impactions, 2 or more.

We will have ~~thirty~~ (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

~~**PART 4 – EXCLUSIONS**~~

~~The following exclusions are not Covered Services. No payments will be made by Us for these services:~~

~~(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;~~

~~(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;~~

~~(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;~~

~~(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;~~

~~(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;~~

~~(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;~~

~~(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;~~

~~(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;~~

~~(9) Implants, implant services and implant supported prosthetics are not covered for patients~~

~~under the age of 16;~~

~~(10) Expenses incurred for veneers and related procedures;~~

~~(11) Replacement of a lost or stolen or discarded prosthetic device;~~

~~(12) Adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;~~

~~(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;~~

~~(14) If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;~~

~~(15) X rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;~~

~~(16) The extraction of immature erupting third molars and non pathologic, asymptomatic third molar extractions;~~

~~(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;~~

~~(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;~~

~~(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;~~

~~(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;~~

~~(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);~~

~~(22) Expenses incurred for congenital or developmental malformations;~~

~~(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);~~

~~(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;~~

~~(25) Chemotherapeutic agents and any other experimental procedures;~~

~~(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;~~

~~(27) Expenses that are applied toward satisfaction of a Deductible, if any;~~

~~(28) Services and supplies performed outside of the United States of America;~~

~~(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;~~

~~(30) Expenses for services for which You would not legally have to pay if there were no insurance;~~

~~(31) Services not completed on or before the date of termination;~~

~~(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;~~

~~(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;~~

~~(34) Expenses incurred for services covered on a pediatric only dental plan.~~

PART ~~5~~4 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:

(1) Your lawful spouse or domestic partner and

(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or

(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:

(1) A full-time permanent employee who is:
   (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
   (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or

(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 56 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect on the later of:

(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or

(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or

(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:

(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or

(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;

(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;

(3) the date Insured ceases to be in a class eligible for insurance under this plan;

(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;

(5) the day before the due date of any premium that remains unpaid at the end of the grace period;

(6) the date the Group Policy terminates;

(7) the date the Subscriber's Employer ceases to be a Participating Employer;

(8) the date the number of the Participating Employer's Subscribers falls below 2;

(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or

(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:

(1) the date Your insurance terminates;

(2) the date You fail to make a contribution for dependent insurance;

(3) the date You cease to be in a class eligible for dependent insurance; or

(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 67 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such

payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 7~~8~~ –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 8~~9~~ – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or
(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy

provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8),

You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.

(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:

(1) the due date to pay any required premium (if premium is not paid by that date).

(2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.

(3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)

(4) a date which is:

1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 9~~10~~ – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on

which the decision was based.

~~**PART 11 - SUMMARY PLAN DESCRIPTION SUPPLEMENT**~~

~~The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of your Certificate, it forms the Summary Plan Description.~~

~~(1) NAME OF PLAN: [Beneficial Employees Security Trust], [P.O. Box 3100, Newport Beach, California 92658-9027].~~

~~(2) PLAN IDENTIFICATION NUMBER: [501].~~

~~(3) TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN: The plan is administered by [BEST Life and Health Insurance Company] located at [2505 McCabe Way, Irvine, California 92614], [(800) 433-0088]. Benefits are insured in accordance with the Group Dental Insurance Policy issued by BEST Life.~~

~~(4) AGENT FOR SERVICE: The Chief Legal counsel of BEST Life at [the above address].~~

~~(5) TRUSTEE OF THE PLAN: [Wells Fargo Bank, N.A., 180 South Main Street, 2nd Floor, Salt Lake City, Utah 84101].~~

~~(6) SOURCE OF PLAN CONTRIBUTION: The contributions necessary to finance the plan are made by the employer and employees.~~

~~(7) DATE OF END OF THE PLAN'S FISCAL YEAR: [December 31].~~

PART 1~~0~~2 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a

request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

VARIABILITY STATEMENT

GFD-PPO-POL-0113TN

Title Page – The address of the company may change.

Page 2 – The President and Secretary of the company may change.

Page 3 – Specific to the Client.

Table of Contents – page numbers may change. The subheadings under Benefits and Exclusions will show either the Pediatric Plan provisions only or all provisions

Schedule of Benefits –

- **Policyholder** –Is bracketed to allow this product to be offered to any employer group.
- **Table of Benefits** - We are offering four "supplemental" plan designs and two pediatric dental plans. We have provided the full range of possibilities that would apply. In the final Certificate, only the plans that are selected will appear. A pediatric plan will always be shown.
- **The 80th percentile** – this is bracketed to allow either the 80th or 90th percentile to be offered.
- **Orthodontic benefits** – 24 month wait is bracketed on medically necessary orthodontia to allow no waiting period.
- **Major Dentistry Waiting Period Waiver –** Our supplemental plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate. This section does not apply to pediatric and will only appear below the Supplemental dental plan.

Part 2 Benefits and Exclusions –

- **24 Month Wait for Medically Necessary Orthodontic Benefits –** bracketed to allow for no waiting period.
- **Optional Child Orthodontic Benefits**
- We may offer child orthodontic benefits as an option depending on the size of the group. This whole section is bracketed. Only plans with this option will have this in the certificate.
- We have bracketed the option to pay benefits at 1/3 or ½ of covered benefit. We will market with 1/3, but want the option to change the benefit to ½ for new contracts.
- 12-month wait on orthodontic procedures may apply depending on group size. This statement will not appear on plans that do not have a waiting period. 12 is bracketed to allow 24 month wait.
- **Class III Major Dental Procedures** - We may offer a 12-month wait on Major Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate.
- **Implants** – We may not offer this benefit on all plans.
- **Supplemental Dental Accident Benefit** – this is bracketed in case we do not want to offer this benefit. It is also bracketed in the Schedule of Benefits.
- **Exclusions** – we have bracketed the exclusions for the Supplemental Plan. Implants has been bracketed to match the benefit offering that would or would not be available on the plan.

Effective Date for the Employee - Item #3 is bracketed and will be specific to the Client.

The Client may not want coverage effective on the date the employee qualifies.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

GFD-PPO-CERT-0113TN **Title Page** –The address of the company may change.

Page 2 – The President and Secretary of the company may change.

Statement of Coverage – Group and Insured information will be provided in the bracketed fields.

- **Subscriber Name –** Specific to individual purchasing the plan.
- **Certificate Effective Date –** Specific to the plan year for the Exchange.
- **Insured name(s) and Effective Dates(s) –** specific to client.
- **Participating Employer and Employer Number** – specific to client.
- **Plan information** – We are transitioning to a new administrative system. Our current administrative system provides plan selection information in the Statement of Coverage. The new administrative system will provide this information in the Schedule of Benefits. The Plan, Deductible, Annual Maximum, waiting period waiver is bracketed because these fields will no longer be provided once the new system is up and running.
- **Group Policy Number** – Specific to the client.

Table of Contents – page numbers may change. The subheadings under Benefits and Exclusions will show either the Pediatric Plan provisions only or all provisions

Schedule of Benefits –

- **Policyholder** – **Policyholder** –Is bracketed to allow this product to be offered to any employer group.
  - **Table of Benefits** - We are offering four "supplemental" plan designs and two pediatric dental plans. We have provided the full range of possibilities that would apply. In the final Certificate, only the plans that are selected will appear. A pediatric plan will always be shown.
  - **The 80th percentile** – this is bracketed to allow either the 80th or 90th percentile to be offered.
  - **Orthodontic benefits** – 24 month wait is bracketed on medically necessary orthodontia to allow no waiting period.
  - **Major Dentistry Waiting Period Waiver –** Our supplemental plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate. This section does not apply to pediatric and will only appear below the Supplemental dental plan.

Part 2 Benefits and Exclusions –

- **24 Month Wait for Medically Necessary Orthodontic Benefits –** bracketed to allow for no waiting period.

- Optional Child Orthodontic Benefits
  - We may offer child orthodontic benefits as an option depending on the size of the group. This whole section is bracketed. Only plans with this option will have this in the certificate.
  - We have bracketed the option to pay benefits at 1/3 or ½ of covered benefit. We will market with 1/3, but want the option to change the benefit to ½ for new contracts.
  - 12-month wait on orthodontic procedures may apply depending on group size. This statement will not appear on plans that do not have a waiting period. 12 is bracketed to allow 24 month wait
- Class III Major Dental Procedures - We may offer a 12-month wait on Major Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate.
- Implants – We may not offer this benefit on all plans.
- Supplemental Dental Accident Benefit – this is bracketed in case we do not want to offer this benefit. It is also bracketed in the Schedule of Benefits.
- Exclusions – we have bracketed the exclusions for the Supplemental Plan. Implants has been bracketed to match the benefit offering that would or would not be available on the plan.

Effective Date for the Employee - Item #3 is bracketed and will be specific to the Client. The Client may not want coverage effective on the date the employee qualifies.

General Provisions

- Notice of Claim – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

GFD-PPO-EAP-0113TN

Title of Application – plan name is bracketed.
Dental Plan Selection – the plan names are bracketed since the name may change. We are providing the full range of benefits possible within the brackets for each benefit level.
Waiting Period Waiver – We currently offer waiting period waivers for groups based on group size and if they have prior coverage. We would like to offer the same waiting period waivers if we provide waiting periods on major and orthodontic services on our Supplemental plans. This section will be taken out if no waiting periods are offered on the Supplemental dental plans.

GFD-EN-CO-0113

- Address may change.
- 12-month wait on orthodontic procedures may apply depending on group size. This statement will not appear on plans that do not have a waiting period.
- We have bracketed the option to pay benefits at 1/3 or ½ of covered benefit. We will market with 1/3, but want the option to change the benefit to ½ for new contracts. 12 is bracketed to allow for a 24 month wait.
- The Lifetime Maximum and other benefits will appear on the Schedule of Benefits. We have bracketed this in case we want this to appear elsewhere, i.e. the Statement of Coverage.
- Signatures - Officers may change.

GFD-END-SA-0113

- The address may change
- This benefit may be offered at $1,000 or $500. Only one benefit amount will appear, depending on the plan selected.
- Signatures – officers may change.

BEST Life™
BEST Life and Health Insurance Company

Actuarial Memorandum

Scope and Purpose

This is a new product rate filing to satisfy the Stand-Alone Adult and Pediatric Dental Plans Rate Filing requirements for the Tennessee Health Benefit Plan under group policy numbers GPD-PPO-POL-0113TN and GAD-PPO-POL-0113TN.

Description of Benefits

The policies provide benefits for two small group stand-alone dental products: a Pediatric Dental Only Plan and an Adult Dental Plan. These plans are designed to be offered either through the Beneficial Employees Security Trust of Utah, which is situated in the State of Utah. These plans will be marketed to employer groups through the Tennessee SHOP Exchange market.

Children to age 20 are eligible to enroll on the Pediatric Dental Only Plan. Adults and child dependents age 21 through age 25 are eligible for coverage as long as the adults are full-time employees, or part-time employees if the employer so chooses.

Benefit Renewability

The policies are standard group contracts, to be issued to employer-sponsored groups and group associations. Coverage for individuals is renewable at the option of the policyholder. The Company reserves the right to increase premiums.

Proposed Effective Date

January 1, 2014

Description of Rate Calculations

- Base claim costs are developed using our company California claims experience from 2010 to 2012.
- Base claim costs are adjusted to reflect the plan design and adjusted for area using the 2010 HealthMaps Dental Rate Manual and Milliman study dated November 2012.
- A dental trend factor of approximately 4% per year is used to project future expected claims and is included in the premium rate structure
- Standard company retention of 30.75% (administration – 12%, premium tax – 1.75%, user fees – 3.5%, commissions – 10% and profit – 3.5%) is applied.

BEST Life™
BEST Life and Health Insurance Company

Anticipated Future Loss Ratio

The anticipated future loss ratio for this policy is expected to be 69.25%. The loss ratio is computed as follows:

$$\text{Loss Ratio} = \frac{\text{Expected Incurred Claims}}{\text{Expected Earned Premium}}$$

Incurred claims are total claims for covered expenses paid on behalf of a covered person while coverage is in force, summed for all covered persons. Earned premium is the premium for each covered person for the period coverage is in force, summed for all covered persons.

I, Adam S. Chan, Actuary for BEST Life and Health Insurance Company ("BEST"), NAIC #90638, domiciled in Texas, do hereby certify that to the best of my knowledge and judgment, this rate submission is in compliance with the applicable laws and regulations of Tennessee and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the attached rates are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory.

Adam Chan, A.S.A., M.A.A.A.
Corporate Actuary
BEST Life and Health Insurance Company
Irvine, California

April 30, 2013
Date

BEST Life and Health Insurance Company

Tennessee Health Insurance Exchange Rate Filing

Small Employer Group Dental - Essential Pediatric Plans

	High Plan - Actuarial Value 84%		Low Plan - Actuarial Value 69%	
	1 child	2 or more child	1 child	2 or more child
Base Cost	$ 57.35	$ 112.60	$ 50.59	$ 99.34
Trend	1.12	1.12	1.12	1.12
Area factor	0.80	0.80	0.80	0.80
Net Cost	$ 51.55	$ 101.21	$ 45.48	$ 89.29
Administrative	12.00%	12.00%	12.00%	12.00%
Premium Tax	1.75%	1.75%	1.75%	1.75%
User Fees*	3.50%	3.50%	3.50%	3.50%
Broker Commission	10.00%	10.00%	10.00%	10.00%
Profit	3.50%	3.50%	3.50%	3.50%
Target Loss Ratio	69.25%	69.25%	69.25%	69.25%
Final Rate*	$ 74.44	$ 146.16	$ 65.67	$ 128.94

** User fees of 3.5% imposed by the Department of Health and Human Services are included.*

BEST Life™

BEST Life and Health Insurance Company

Tennessee Health Insurance Exchange Rate Filing

Small Employer Group Dental - Supplemental Plans

	High Plan	Mid Plan	Basic Plan	Value Plan
Base Cost	$ 75.21	$ 67.08	$ 46.96	$ 30.67
Trend	1.12	1.12	1.12	1.12
Area factor	0.80	0.80	0.80	0.80
Net Cost	$ 67.61	$ 60.30	$ 42.21	$ 27.57
Administrative	12.00%	12.00%	12.00%	12.00%
Premium Tax	1.75%	1.75%	1.75%	1.75%
User Fees*	3.50%	3.50%	3.50%	3.50%
Broker Commission	10.00%	10.00%	10.00%	10.00%
Profit	3.50%	3.50%	3.50%	3.50%
Target Loss Ratio	69.25%	69.25%	69.25%	69.25%
Final Voluntary Tier Rates*				
Employee	$ 107.78	$ 96.13	$ 67.29	$ 43.96
Employee + Spouse	$ 219.85	$ 196.10	$ 137.26	$ 89.66
Employee + Children	$ 231.57	$ 206.55	$ 144.57	$ 94.44
Employee + Family	$ 375.37	$ 334.81	$ 234.35	$ 153.09
Final Employer-Contributory Tier Rates*				
Employee	$ 94.84	$ 84.60	$ 59.21	$ 38.68
Employee + Spouse	$ 193.47	$ 172.57	$ 120.79	$ 78.90
Employee + Children	$ 203.78	$ 181.76	$ 127.22	$ 83.11
Employee + Family	$ 330.32	$ 294.63	$ 206.23	$ 134.72

** User fees of 3.5% imposed by the Department of Health and Human Services are included.*

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Policy provides dental coverage only.

GAD-PPO-POL-0113TN

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Utah. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: Beneficial Employees Security Trust of Utah

Group Policy Effective Date: [XX-XX-XXXX] **Group Policy Number:** [XXX]

State of Delivery: Utah

Premiums Due On: 1st of each month **First Renewal Date:** [XX-XX-XXXX]

[Intentionally Blank Page]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [The Trustee of the Beneficial Employees Security Trust of Utah.]

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

	[PPO Dental High] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[1,000 – 1,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	100%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	90%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	60%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Basic	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Mid] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,500	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	50%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Basic] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	50%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]
[

	[PPO Dental Value] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	50%	20%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[**Major Dentistry Waiting Period Waiver**
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS

Covered Services

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every 12 months per individual;
(2) Bitewing x-rays not more often than once every 12 months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five years; any combination of eight or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
    (a) root recovery (surgical removal of residual root);
    (b) oral antral fistula closure;
    (c) removal of a dentigerous or odontogenic cyst;
    (d) incision and drainage of an abscess;
    (e) removal of lateral exostosis;
    (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;

(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
   (a) accidental injury requiring oral surgical treatment, or
   (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven years after the date of installation, unless:
   (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
   (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
   (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
   (b) implant supported prosthetics;
   (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
   (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
   (e) implant maintenance.

[**Note:** Unless the twelve (12) month waiting period requirement for Orthodontic Procedures has been met, the services below are not covered benefits for any treatment that begin during the twelve (12) month period immediately following Your effective date of coverage.]

[**CLASS IV – Orthodontic Procedures Include:**
Provides orthodontic treatment for Dependent children until the end of the month of their 18th birthday, to be payable as follows:

(1) All procedures performed in connection with orthodontic treatment subject to the coinsurance level, Calendar Year and Lifetime Maximum Benefit as defined in the Schedule of Benefits;
(2) Benefits for the initial placement up to [1/3][1/2] of the Lifetime Maximum Benefit Amount, as an initial down payment;
(3) Periodic follow-up visits will be payable on a monthly basis during the scheduled course of orthodontic treatment, up to the Lifetime Maximum Amount;
(4) Orthodontic benefits end once braces are removed or at the cancellation of coverage, whichever comes first.]

Supplemental Dental Accident Benefit

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, two (2) or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, two (2) or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) Two (2) or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, two (2) or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible

amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

PART 4 – EXCLUSIONS

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics are not covered for patients under the age of 16;
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;

(12) Adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the “Schedule of Dental Benefits” section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.

PART 5 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the

Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:
(1) Your lawful spouse or domestic partner and
(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:
(1) A full-time permanent employee who is:
    (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
    (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or
(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect

on the later of:
(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or
(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or
(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured’s coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 7 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary.

This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 8 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal

premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 9 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is

continued for any other reason.

PART 10 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 11 - SUMMARY PLAN DESCRIPTION SUPPLEMENT

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of your Certificate, it forms the Summary Plan Description.

(1) NAME OF PLAN: [Beneficial Employees Security Trust], [P.O. Box 3100, Newport Beach, California 92658-9027].
(2) PLAN IDENTIFICATION NUMBER: [501].
(3) TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN: The plan is administered by [BEST Life and Health Insurance Company] located at [2505 McCabe Way, Irvine, California 92614], [(800) 433-0088]. Benefits are insured in accordance with the Group Dental Insurance Policy issued by BEST Life.
(4) AGENT FOR SERVICE: The Chief Legal counsel of BEST Life at [the above address].
(5) TRUSTEE OF THE PLAN: [Wells Fargo Bank, N.A., 180 South Main Street, 2nd Floor, Salt Lake City, Utah 84101].
(6) SOURCE OF PLAN CONTRIBUTION: The contributions necessary to finance the plan are made by the employer and employees.

(7) DATE OF END OF THE PLAN'S FISCAL YEAR: [December 31].

PART 12 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Certificate provides dental coverage only.

GAD-PPO-CERT-0113TN

CERTIFICATE OF GROUP INSURANCE

Issued By

BEST Life and Health Insurance Company

A STOCK COMPANY
(Herein called the "We," "Us," "Company" or "BEST Life")

BEST Life and Health Insurance Company certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Group Policy. The Group Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Group Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

PLAN EFFECTIVE DATE: Insurance is in effect on the date shown on the Certificate Statement of Coverage.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Utah. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].

[ ]

President

[ ]

Secretary

GROUP PPO DENTAL
NON-PARTICIPATING

THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.

[Intentionally Blank Page]

This Certificate Is Not Valid
Unless There Is a Complete Statement of Coverage

Statement of Coverage

DENTAL

INSURANCE SUBSCRIBER NAME: [JOHN D. DOE]
CERTIFICATE EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):
[JANE DOE 01/01/2014]
[JON DOE 01/01/2014]

PARTICIPATING EMPLOYER NAME: [CUSTOMER NAME]
PARTICIPATING EMPLOYER NUMBER: [TN00XXX0000XX]

[PLAN: [PPO HIGH]
DEDUCTIBLE: [$50]
ANNUAL MAXIMUM: [$1,000]]

GROUP POLICY No.: [XXXXXXXXX]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [The Trustee of the Beneficial Employees Security Trust of Utah.]

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

	[PPO Dental High] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[1,000 – 1,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	100%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	90%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	60%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Basic	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Mid] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,500	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	50%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Basic] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	50%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]
[

	[PPO Dental Value] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	50%	20%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS

Covered Services

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every 12 months per individual;
(2) Bitewing x-rays not more often than once every 12 months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five years; any combination of eight or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
    (a) root recovery (surgical removal of residual root);
    (b) oral antral fistula closure;
    (c) removal of a dentigerous or odontogenic cyst;
    (d) incision and drainage of an abscess;
    (e) removal of lateral exostosis;
    (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;

(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
   (a) accidental injury requiring oral surgical treatment, or
   (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven years after the date of installation, unless:
   (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
   (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
   (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
   (b) implant supported prosthetics;
   (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
   (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
   (e) implant maintenance.

[**Note:** Unless the twelve (12) month waiting period requirement for Orthodontic Procedures has been met, the services below are not covered benefits for any treatment that begin during the twelve (12) month period immediately following Your effective date of coverage.]

[**CLASS IV – Orthodontic Procedures Include:**
Provides orthodontic treatment for Dependent children until the end of the month of their 18th birthday, to be payable as follows:

(1) All procedures performed in connection with orthodontic treatment subject to the coinsurance level, Calendar Year and Lifetime Maximum Benefit as defined in the Schedule of Benefits;
(2) Benefits for the initial placement up to [1/3][1/2] of the Lifetime Maximum Benefit Amount, as an initial down payment;
(3) Periodic follow-up visits will be payable on a monthly basis during the scheduled course of orthodontic treatment, up to the Lifetime Maximum Amount;
(4) Orthodontic benefits end once braces are removed or at the cancellation of coverage, whichever comes first.]

Supplemental Dental Accident Benefit

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, two (2) or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, two (2) or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) Two (2) or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, two (2) or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible

amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

PART 4 – EXCLUSIONS

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics are not covered for patients under the age of 16;
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;

(12) Adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the “Schedule of Dental Benefits” section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.

PART 5 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the

Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:
(1) Your lawful spouse or domestic partner and
(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:
(1) A full-time permanent employee who is:
  (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
  (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or
(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect

on the later of:
(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or
(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or
(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured’s coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 7 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary.

This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 8 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal

premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 9 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is

continued for any other reason.

PART 10 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 11 - SUMMARY PLAN DESCRIPTION SUPPLEMENT

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of your Certificate, it forms the Summary Plan Description.

(1) NAME OF PLAN: [Beneficial Employees Security Trust], [P.O. Box 3100, Newport Beach, California 92658-9027].
(2) PLAN IDENTIFICATION NUMBER: [501].
(3) TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN: The plan is administered by [BEST Life and Health Insurance Company] located at [2505 McCabe Way, Irvine, California 92614], [(800) 433-0088]. Benefits are insured in accordance with the Group Dental Insurance Policy issued by BEST Life.
(4) AGENT FOR SERVICE: The Chief Legal counsel of BEST Life at [the above address].
(5) TRUSTEE OF THE PLAN: [Wells Fargo Bank, N.A., 180 South Main Street, 2nd Floor, Salt Lake City, Utah 84101].
(6) SOURCE OF PLAN CONTRIBUTION: The contributions necessary to finance the plan are made by the employer and employees.

(7) DATE OF END OF THE PLAN'S FISCAL YEAR: [December 31].

PART 12 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

VARIABILITY STATEMENT

GAD-PPO-POL-0113TN

Title Page – The address and officers of the company may change; Policy.

Page 2 – The President and Secretary of the company may change.

Page 3 – Specific to the Client.

Policyholder – Is the trustee of the Beneficial Employees Security Trust of Utah. Is bracketed in case the name of the trust changes.

Schedule of Benefits – we are offering four plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

Major Dentistry Waiting Period Waiver – Our plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate.

Part 2 Benefits – We may offer a 12-month wait on Major and Orthodontic Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate. Orthodontic benefits are bracketed since this is an optional benefit only. Plans that do not have Orthodontia will not have this information provided in their Certificate.

CLASS IV – Orthodontic Procedures – will only appear on plans that include coverage for child Orthodontia. Payment may be offered at 1/3 or 1/2 of the Lifetime Maximum Benefit. Only one of these will be chosen at the time we implement these plans. It is bracketed in case we want to change this benefit for new contracts at a later time.

Definitions -- Eligible Dependent (2), the limiting age is bracketed so that employers with pediatric benefits embedded in their medical plan have the option of defining eligible children as those between 20 and 26 years of age.

Effective Date for the Employee - Item #3 is bracketed and will be specific to the Client. The Client may not want coverage effective on the date the employee qualifies.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

Summary Plan Description Supplement – Bracketed information will be specific to the Policyholder, addresses may change.

GAD-PPO-CERT-0113TN

Title Page –The address of the company may change.

Page 2 – The President and Secretary of the company may change.

Statement of Coverage – Group and Insured information will be provided in the bracketed fields.

- **Subscriber Name –** Specific to individual purchasing the plan.
- **Certificate Effective Date –** Specific to the plan year for the Exchange.
- **Insured name(s) and Effective Dates(s) –** specific to client.
- **Participating employer name and number –** specific to the client.
- **Plan information** – We are transitioning to a new administrative system. Our current administrative system provides plan selection information in the Statement of Coverage. The new administrative system will provide this information in the Schedule of Benefits. The Plan, Deductible, and Annual Maximum is bracketed because these fields will no longer be provided once the new system is up and running.
- **Group Policy Number** – Specific to the client.

Policyholder – Is the trustee of the Beneficial Employees Security Trust of Utah. Is bracketed in case the name of the trust changes.

Schedule of Benefits – we are offering four plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

Major Dentistry Waiting Period Waiver – Our plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate.

Part 2 Benefits – We may offer a 12-month wait on Major and Orthodontic Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate. Orthodontic benefits are bracketed since this is an optional benefit only. Plans that do not have Orthodontia will not have this information provided in their Certificate.

CLASS IV – Orthodontic Procedures – will only appear on plans that include coverage for child Orthodontia. Payment may be offered at 1/3 or 1/2 of the Lifetime Maximum Benefit. Only one of these will be chosen at the time we implement these plans. It is bracketed in case we want to change this benefit for new contracts at a later time.

Definitions – Eligible Dependent (2), the limiting age is bracketed so that employers with pediatric benefits embedded in their medical plan have the option of defining eligible children as those between 20 and 26 years of age.

Effective Date for the Employee - Item #3 is bracketed and will be specific to the Client. The Client may not want coverage effective on the date the employee qualifies.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is

provided.

- Appealing the denial of a claim – address may change.

Summary Plan Description Supplement – Bracketed information will be specific to the Policyholder, addresses may change.

GAD-PPO-EAP-0113TN

Title of Application – plan name is bracketed.

Dental Plan Selection – the plan names are bracketed since the name may change. We are providing the full range of benefits possible within the brackets for each benefit level.

Waiting Period Waiver – We currently offer waiting period waivers for groups based on group size and if they have prior coverage. We would like to offer the same waiting period waivers if we provide waiting periods on major and orthodontic services on our Supplemental (Adult Only) plans. This section will be taken out if no waiting periods are offered on the Supplemental (Adult Only) dental plans.

Group Insurance Policy

Dental PPO Pediatric Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Policy provides dental coverage for children only.

GPD-PPO-POL-0113TN

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Utah. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: Beneficial Employees Security Trust of Utah

Group Policy Effective Date: [XX-XX-XXXX]

Group Policy Number: [XXX]

State of Delivery: Utah

Premiums Due On: 1st of each month

First Renewal Date: [XX-XX-XXXX]

[Intentionally Blank Page]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [The Trustee of the Beneficial Employees Security Trust of Utah]

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

	PPO High Pediatric Dental Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Basic and Major services received In-Network or Out-of-Network	$0	$50
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	90%
Basic Services Coinsurance – Fillings	70%	60%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	50%	40%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50%	50%

]

[

	PPO Low Pediatric Dental Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive, Basic and Major services received In-Network or Out-of-Network	$50	$100
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	60%
Basic Services Coinsurance – Fillings	55%	40%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	35%	20%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50%	50%

]

PART 2 - BENEFITS

Covered Services

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every 6 months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every 12 months;
(3) Topical fluoride varnish not more often than twice every 12 months;
(4) Sealants not more often than once per tooth in a 36-month period and limited to unrestored permanent molars for individuals under age 19;
(5) Space maintainers, including re-cementation, for individuals under age 19 (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every 6 months;
(7) Limited oral evaluation (problem focused) not more often than once every 6 months;
(8) Comprehensive oral evaluation not more often than once every 6 months;
(9) Comprehensive periodontal evaluation not more often than once every 6 months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every 6 months;

(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a 60-month period for individuals under age 15;
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within 45 days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within 45 days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age 6, and limited to primary molars and cuspids for individuals up to age 11;
(6) Periodontal scaling and root planning, per quadrant, not more often than once every 24 months;
(7) Periodontal maintenance not more often than four in a 12-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a 36-month period, 6 months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;
    f. tooth reimplantation;
    g. surgical access of unerupted tooth;
    h. alveoloplasty;
    i. removal of exostosis;
    j. incision and drainage of abscess;
    k. suture of recent small wounds up to 5 cm
    l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every 60 months;
(3) Endodontics (rooth canal)
(4) Gingivectomy or gingivoplasty, four or more teeth not more often than once every 36 months;
(5) Gingival flap procedure, four or more teeth not more often than once every 36 months;
(6) Osseous surgery, four or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every 36 months;
(7) Full mouth debridement limited to one per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every 60 months (excludes interim dentures);

(9) Implants and implant services once every 60 months only if medically necessary;
(10) Occlusal guard not more often than once in 12 months for individuals 13 and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

Class IV – Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:
(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:
(1) Medically necessary service or supplies;

(2) Crowns (other than stainless steel);
(3) Apicoectomy;
(4) Non-emergency third molar extractions;
(5) Maxillofacial prosthetics;
(6) Orthodontia;
(7) Emergency room services provided by a dentist; and
(8) Inpatient hospital services.

We will have 30 days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

PART 4 – EXCLUSIONS

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a 5-year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;

(12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;
(13) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(14) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(15) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(16) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(17) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(18) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(19) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(20) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(21) Services not completed on or before the date of termination;
(22) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(23) Expenses that are applied toward satisfaction of a Deductible, if any;
(24) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(25) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(26) Chemotherapeutic agents and any other experimental procedures;
(27) Expenses incurred for veneers and related procedures;
(28) Services and supplies performed outside of the United States of America.

PART 5 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Out-of-Pocket Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person who is less than 20 years of age on the effective date of the person's coverage.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: A Child, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted from the date of placement, any child for whom the Subscriber has been granted legal custody, or a Child named in a Qualified Medical Child Support Order or other court or administrative order.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: Any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Out-of-Pocket Maximum: The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental care or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into

consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Insured.

PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Dependent: Your Dependent's insurance will take effect on the later of:

(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or

(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within 31 days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than 31 days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured’s coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

PART 7 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured you is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of

the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 8 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of

reinstatement. The reinstated policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 9 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the policy.

Right to Contest: After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and

Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 10 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 11 - SUMMARY PLAN DESCRIPTION SUPPLEMENT

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of your Certificate, it forms the Summary Plan Description.

(1) NAME OF PLAN: [Beneficial Employees Security Trust], [P.O. Box 3100, Newport Beach, California 92658-9027].
(2) PLAN IDENTIFICATION NUMBER: [501].
(3) TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN: The plan is administered by [BEST Life and Health Insurance Company] located at [2505 McCabe Way, Irvine, California 92614], [(800) 433-0088]. Benefits are insured in accordance with the Group Dental Insurance Policy issued by BEST Life.
(4) AGENT FOR SERVICE: The Chief Legal counsel of BEST Life at [the above address].
(5) TRUSTEE OF THE PLAN: [Wells Fargo Bank, N.A., 180 South Main Street, 2nd Floor, Salt Lake City, Utah 84101].
(6) SOURCE OF PLAN CONTRIBUTION: The contributions necessary to finance the plan are made by the employer and employees.
(7) DATE OF END OF THE PLAN'S FISCAL YEAR: [December 31].

PART 12 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within 30 days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Group Insurance Policy

Dental PPO Pediatric Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Certificate provides dental coverage for children only.

GPD-PPO-CERT-0113TN

CERTIFICATE OF GROUP INSURANCE

Issued By

BEST Life and Health Insurance Company

A STOCK COMPANY
(Herein called the "We," "Us," "Company" or "BEST Life")

BEST Life and Health Insurance Company certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Group Policy. The Group Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Group Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

PLAN EFFECTIVE DATE: Insurance is in effect on the date shown on the Certificate Statement of Coverage.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Utah. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].

[ ] [ ]

President **Secretary**

GROUP PPO PEDIATRIC
DENTAL NON-PARTICIPATING

THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.

[Intentionally Blank Page]

This Certificate Is Not Valid
Unless There Is a Complete Statement of Coverage

Statement of Coverage

PEDIATRIC DENTAL

INSURANCE SUBSCRIBER NAME: [JOHN D. DOE]
CERTIFICATE EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):
[JANE DOE 01/01/2014]
[JON DOE 01/01/2014]

PARTICIPATING EMPLOYER NAME: [CUSTOMER NAME]
PARTICIPATING EMPLOYER NUMBER: [OR00XXX0000XX]

[**PLAN:** [PPO HIGH]
DEDUCTIBLE: [$50]
OUT OF POCKET MAXIMUM: [$700]]

GROUP POLICY NO.: [XXXXXXXXX]]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [The Trustee of the Beneficial Employees Security Trust of Utah]

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

	PPO High Pediatric Dental Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Basic and Major services received In-Network or Out-of-Network	$0	$50
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	90%
Basic Services Coinsurance – Fillings	70%	60%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	50%	40%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50%	50%

]

[

	PPO Low Pediatric Dental Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive, Basic and Major services received In-Network or Out-of-Network	$50	$100
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	60%
Basic Services Coinsurance – Fillings	55%	40%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	35%	20%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50%	50%

]

PART 2 - BENEFITS

Covered Services
Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every 6 months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every 12 months;
(3) Topical fluoride varnish not more often than twice every 12 months;
(4) Sealants not more often than once per tooth in a 36-month period and limited to unrestored permanent molars for individuals under age 19;
(5) Space maintainers, including re-cementation, for individuals under age 19 (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every 6 months;
(7) Limited oral evaluation (problem focused) not more often than once every 6 months;
(8) Comprehensive oral evaluation not more often than once every 6 months;
(9) Comprehensive periodontal evaluation not more often than once every 6 months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every 6 months;

(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a 60-month period for individuals under age 15;
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within 45 days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within 45 days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age 6, and limited to primary molars and cuspids for individuals up to age 11;
(6) Periodontal scaling and root planning, per quadrant, not more often than once every 24 months;
(7) Periodontal maintenance not more often than four in a 12-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a 36-month period, 6 months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;
    f. tooth reimplantation;
    g. surgical access of unerupted tooth;
    h. alveoloplasty;
    i. removal of exostosis;
    j. incision and drainage of abscess;
    k. suture of recent small wounds up to 5 cm
    l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every 60 months;
(3) Endodontics (rooth canal)
(4) Gingivectomy or gingivoplasty, four or more teeth not more often than once every 36 months;
(5) Gingival flap procedure, four or more teeth not more often than once every 36 months;
(6) Osseous surgery, four or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every 36 months;
(7) Full mouth debridement limited to one per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every 60 months (excludes interim dentures);

(9) Implants and implant services once every 60 months only if medically necessary;
(10) Occlusal guard not more often than once in 12 months for individuals 13 and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

Class IV – Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:
(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:
(1) Medically necessary service or supplies;

(2) Crowns (other than stainless steel);
(3) Apicoectomy;
(4) Non-emergency third molar extractions;
(5) Maxillofacial prosthetics;
(6) Orthodontia;
(7) Emergency room services provided by a dentist; and
(8) Inpatient hospital services.

We will have 30 days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

PART 4 – EXCLUSIONS

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a 5-year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;

(12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;
(13) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(14) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(15) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(16) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(17) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(18) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(19) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(20) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(21) Services not completed on or before the date of termination;
(22) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(23) Expenses that are applied toward satisfaction of a Deductible, if any;
(24) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(25) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(26) Chemotherapeutic agents and any other experimental procedures;
(27) Expenses incurred for veneers and related procedures;
(28) Services and supplies performed outside of the United States of America.

PART 5 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Out-of-Pocket Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person who is less than 20 years of age on the effective date of the person's coverage.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: A Child, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted from the date of placement, any child for whom the Subscriber has been granted legal custody, or a Child named in a Qualified Medical Child Support Order or other court or administrative order.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: Any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Out-of-Pocket Maximum: The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental care or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into

consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Insured.

PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Dependent: Your Dependent's insurance will take effect on the later of:

(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or

(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within 31 days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than 31 days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

PART 7 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured you is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of

the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 8 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of

reinstatement. The reinstated policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 9 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the policy.

Right to Contest: After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and

Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

Comment [m1]: Required by TN law

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 10 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 11 - SUMMARY PLAN DESCRIPTION SUPPLEMENT

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of your Certificate, it forms the Summary Plan Description.

(1) NAME OF PLAN: [Beneficial Employees Security Trust], [P.O. Box 3100, Newport Beach, California 92658-9027].
(2) PLAN IDENTIFICATION NUMBER: [501].
(3) TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN: The plan is administered by [BEST Life and Health Insurance Company] located at [2505 McCabe Way, Irvine, California 92614], [(800) 433-0088]. Benefits are insured in accordance with the Group Dental Insurance Policy issued by BEST Life.
(4) AGENT FOR SERVICE: The Chief Legal counsel of BEST Life at [the above address].
(5) TRUSTEE OF THE PLAN: [Wells Fargo Bank, N.A., 180 South Main Street, 2nd Floor, Salt Lake City, Utah 84101].
(6) SOURCE OF PLAN CONTRIBUTION: The contributions necessary to finance the plan are made by the employer and employees.
(7) DATE OF END OF THE PLAN'S FISCAL YEAR: [December 31].

PART 12 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within 30 days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

VARIABILITY STATEMENT

GPD-PPO-POL-0113TN

Title Page – The address and officers of the company may change; Policy.

Page 2 – The President and Secretary of the company may change.

Page 3 – Specific to the Client.

Policyholder – Is the trustee of the Beneficial Employees Security Trust of Utah. Is bracketed in case the name of the trust changes.

Schedule of Benefits – we are offering two plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

GPD-PPO-CERT-0113TN

Title Page –The address of the company may change.

Page 2 – The President and Secretary of the company may change.

Statement of Coverage – Group and Insured information will be provided in the bracketed fields.

- **Subscriber Name –** Specific to individual purchasing the plan.
- **Certificate Effective Date –** Specific to the plan year for the Exchange.
- **Insured name(s) and Effective Dates(s) –** specific to client.
- **Participating employer name and number –** specific to the client.
- **Plan information** – We are transitioning to a new administrative system. Our current administrative system provides plan selection information in the Statement of Coverage. The new administrative system will provide this information in the Schedule of Benefits. The Plan, Deductible, and Annual Maximum is bracketed because these fields will no longer be provided once the new system is up and running.
- **Group Policy Number** – Specific to the client.

Policyholder – Is the trustee of the Beneficial Employees Security Trust of Utah. Is bracketed in case the name of the trust changes.

Schedule of Benefits – we are offering two plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

BEST Life™
BEST Life and Health Insurance Company

[PPO] Dental Plans Employer Application

2505 McCabe Way, Irvine, CA 92614
Requested Effective Date: ☐ 1st or ☐ 15th of the month _____, 20____

Type of Coverage Requested	Supplemental Dental Plans				Essential Pediatric Plans	
Select dental plan	☐ [High]	☐ [Mid]	☐ [Basic]	☐ [Value]	☐ [High]	☐ [Low]
Calendar Year Deductible (Applies to Basic and Major Services)	$50	$50	$50	$50	In $0 Out $50	In $50 Out $100
Maximum Benefit Level	In $1,500 Out $1,500	In $1,500 Out $1,500	In $1,000 Out $1,000	In $1,000 Out $1,000		
Out-of-Pocket Maximum					In $700 Out $1,400	In $700 Out $1,400
Preventive Care Services	In 100% Out 100 %	In 100% Out 80 %	In 100% Out800 %	In 100% Out 80 %	In 100% Out 90%	In 100% Out 60%
Basic Services	In 90% Out 80%	In 80% Out 80%	In 80% Out 50%	In 50% Out 20%	In 70% Out 60%	In 55% Out 40%
Major Services	In 60% Out 50%	In 50% Out 50%	In 0% Out 0%	In 0% Out 0%	In 50% Out 40%	In 35% Out 200%
Endodontics	Basic	Basic	Basic	Basic	Major	Major
Periodontics	Major	Major	Major	Major	Major	Major
Child Orthodontics	$1,000 Lifetime	$1,000 Lifetime	$1,000 Lifetime	$1,000 Lifetime	Medically Necessary	Medically Necessary
Reimbursement Level	80th Percentile	80th Percentile	80th Percentile	80th Percentile	80th Percentile	80th Percentile
Employer Choice Option	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Voluntary Option	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

** Employer is contributing less than 50% for each employee. **Certain requirements apply. Please see Plan Brochure for details.*

EMPLOYER/EMPLOYEE INFORMATION

On Payroll	Full-Time	Eligible	Enrolling	Description of Classes not Eligible

Are any employees applying for coverage currently receiving extended benefits under COBRA? ☐ Yes ☐ No *(If yes, please list names below.)*

The Firm's Waiting Period waived for Present Employees? ☐ Yes ☐ No

All new employees are eligible the first of the month following continuous full-time employment of: ☐ 1st of the month following date of hire
☐ 1 Full Calendar Month (standard) ☐ 2 Full Calendar Months ☐ 3 Full Calendar Months

Employer Contribution _____ % for employees _____ % for dependents *(Note: on employer-sponsored plans, Employer must pay at least 50% for employees.)*

Does Employer have proof of comparable group dental insurance for the past twelve (12) consecutive months? ☐ Yes ☐ No *(A copy of your most recent dental bill listing the covered employees and their effective dates must accompany this application.)*

[Supplemental Dental Only: The 12-month wait on Major and Ortho services is waived for employees and groups based on group size and proof of prior coverage for 12 consecutive months on a comparable group dental plan as follows: Employer-sponsored plans: employees with proof of prior coverage only, who are in a group with prior coverage and 5-9 employees enrolled; all employees in a group with 10+ employees enrolled.
Voluntary plans: employees with proof of prior coverage only, who are in a group with prior coverage and 5-9 employees enrolled; all employees in a group with prior coverage, with 10-24 employees enrolled and 50% participation; if 50% participation is not met, waiver will only apply to employees with proof of prior coverage.]

EMPLOYER ACKNOWLEDGEMENT & ASSOCIATION AND TRUST SUBSCRIBER AGREEMENT

Employer Name				Employer Federal Tax Number	
				( ) -	( ) -
Street Address	City	State	Zip	Telephone Number	Fax Number

Billing Address / P.O. Box	City	State	Zip	Email

Nature of Firm's Business	SIC Code	Firm's Contact for Service and Administration of the Selected Plans

I certify that this is a bona fide business with a legitimate business purpose and which has a true employer-employee relationship with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date and denial of all claims incurred.

I understand and agree that the insurance hereby applied for is not effective until this application and the full initial premium is delivered to, received by and approved by BEST Life and Health Insurance Company.

Termination of Coverage—Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the plan; (2) the date the plan is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium; (4) the date the group policy is terminated; (5) the date the group no longer meets minimum participation requirements. The benefits are subject to all the conditions and limitations of the plan.

Eligible dependent coverage terminates on the earliest of the following: (1) when the dependent no longer meets the definition of a dependent; (2) on the first day of the month in which premiums were not paid; or (3) when the member terminates coverage.

FIRM ELIGIBILITY:

A firm or employer must be an active business operation to request coverage. The business must continue on an active basis to retain eligibility for coverage. Coverage will be terminated on the effective date the business ceases active operation. I understand that if my firm drops in size to 1 employee, and if additional employees are not enrolled and active for coverage within 2 months, all of my selected insurance coverage will be cancelled.

IMPORTANT PLAN INFORMATION

The undersigned Employer understands and agrees that it is establishing an employee welfare benefit plan for its employees. The Employer further understands and agrees that the general definition of an employee is a person who usually works at least 30 hours per week at the firm's business location with federal, state and social security tax withheld from their salary.

The Employer understands that by signing this Trust Subscriber Agreement, it is subscribing to a trust group insurance policy for which Beneficial Employees Security Trust of Utah ("B.E.S.T.") is the Master Group Policy policyholder, which is sponsored by the BEST Employers Association ("BEA") to which the Employer joins. B.E.S.T. receives the subscribing Employer's payment and remits the insurance premium(s) to the insurance carrier(s) or to affiliates, Beneficial Administration and BEST Health Plans that provide services to subscribing employers and to B.E.S.T. One of the insurance carriers is BEST Life and Health Insurance Company ("BEST Life").

The Employer understands that by signing this Trust Subscriber Agreement it shall be bound to all the terms and conditions of the Declaration of Trust, including an agreement that the Trustee shall not be liable to any subscribing employer, to any person insured, or to anyone else in connection with the operation of the Group Insurance Trust Fund. The Master Group Policy is governed by the laws of the state of Utah. However, to the extent that such Policy and/or Certificate of Insurance is in conflict with the laws of another demonstrating statutory governing jurisdiction over an out-of-state multiple employer trust Policy, then such Policy and/or Certificate of Insurance may be amended to comply with the minimum requirements of that State.

The Employer understands that by signing this Trust Subscriber Agreement, it becomes a member of BEA and a $2.00 monthly due will be charged along with the insurance premium for the plan(s) the Employer selects. This will also provide access to benefits offered by BEA and may vary by availability, vendor, or state of residence of the participating employer.

FRAUD NOTICE – The following general Fraud Notice is intended to comply with the laws of your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who, knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information may be guilty of committing a fraudulent insurance act which is a crime and may be subject to criminal prosecution.

X / /

Signature of Company Officer | Print Name & Title | Dated

If using a navigator, navigator's signature required on following page.

GAD-PPO-EAP-0113TN

NAVIGATOR REPORT

(Please Print)

Name _____

It is not necessary to complete the following information if you are currently receiving service fees from BEST Life unless changes in address, etc. need to be made. Please sign and date the form below.

Your Agency Name

Address

City | State | Zip

Who Should Receive the Service Fees? ☐ Navigator ☐ Company/Firm

Social Security Number | Federal Tax ID

Date of Birth | License No. | State

Phone No. | FAX No.

Email Address

(Please Complete)

Special Instructions to BEST Life

1. May we contact the client if we need additional information?
   ☐ Yes ☐ No
2. Is this your first case with BEST Life? ☐ Yes ☐ No
3. This is: ☐ an existing client ☐ a new client with my company
4. Send 'New Client Kit' (certificate book, claim forms, etc.) to:
   ☐ The Navigator ☐ The Client
5. The underwriter assigned to my case should contact me?
   ☐ Yes ☐ No

General Agent (GA):

Please list any special handling needed for this client:

I hereby certify that I hold a valid Life, Accident and Health license issued by the state in which this document was executed and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

1. This firm is a bona fide business establishment and participation requirements are being met.

2. I have advised my client not to terminate any existing coverage until this coverage is approved.

3. Coverage, eligibility provisions, waiting periods and limitations have been fully explained to, and understood by, the Employer identified in this document.

4. I have no right to bind, modify or alter provisions of this program.

I understand and agree that the insurance applied for herein does not begin until this application is received and approved by BEST Life and Health Insurance Company, the insurance certificates are issued and the first premium is received and accepted.

Navigator's Signature:	Print Name:	Date: